GUY'S
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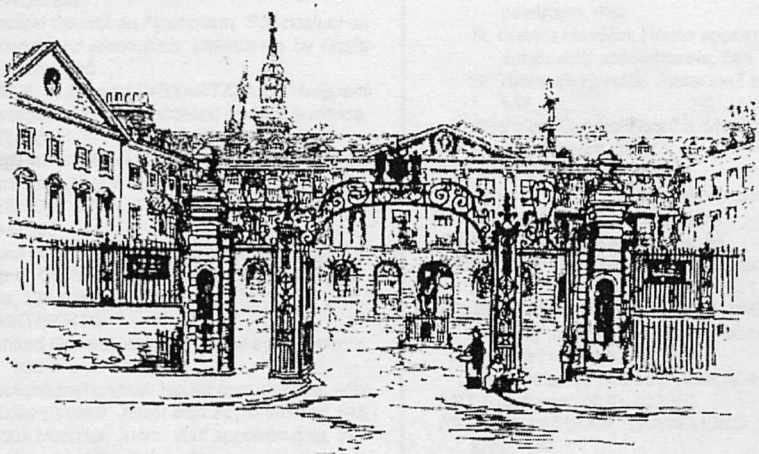

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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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Passim

The Dwindling of First MB/BDS

What a pity if Guy's loses its Preliminary Year Course—the old First MB and First BDS. In the past these courses at Guy's and many other medical and dental schools up and down the country, provided a useful way in to the professions for those students with inappropriate qualifications at A-level grade.

They attracted to medicine and dentistry people with different outlooks and qualifications, often possessing degrees in non-scientific subjects. It was perhaps part of the answer to the Todd Report's call in 1968 for a broadening of entrance requirements for medical schools; something to be supported by those who believe that today's intake of students are too narrowly qualified.

In recent years it has become apparent that this line of thinking runs counter to official policy and today there are at most 100 preliminary year places in English medical schools. In London Guy's offer 18 places and Bart's about 7, though it is rumoured that the Bart's course is soon to close. If that happens our school will be the only one to offer "1st MB" in London.

The numbers of students applying for places has, however, declined, but this may in large part be due to the difficulties in getting local authority grants. Local authorities are much happier if students wishing to enter medical school at a later stage take the appropriate A-levels at their local technical college, but this solution, though cheaper, by no means assures them of a place at medical school at the conclusion of their studies.

Perhaps it is timely to state our support for the Preliminary Year at Guy's, as a way in to medicine and dentistry for committed people with a different background and outlook. We hope that the University Grants Committee and the Nuffield Committee on Dental Education will support us.

An attempt was made to close our Preliminary Year course quite recently and failed, but in spite of its supporters at Guy's—and there are many—it now seems in grave danger of just dwindling away.

Guy's Hospital Gazette

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: 15th February, 1979, and 19th March, 1979.

Copy may be sent to us at 16, St. Thomas Street, SE1 9RT.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (prepaid, minimum £2.00).

Non-subscribers are charged £2.00 (prepaid) for all notices other than Death.

News in Brief

New Years Honours

We heartily congratulate the following Guy's men who were awarded honours in the New Year List: Order of St. Michael and St. George, C.M.G, R. J. W. Rees; C.B.E., T. L. T. Lewis; O.B.E., D. E. Meredith; Diplomatic Service and Overseas List: O.B.E., D. G. Montefiore.

About this month's cover

Our cover this month shows the *"Ship and Shovel"* pub in Southwark from a drawing by Hanslip Fletcher. This public house had friendly associations with Guy's Hospital for over 200 years until it was bombed on the night of 29th December, 1940. It was originally built as the *"Pig and Whistle"* in 1704 and renamed after the death of Admiral Sir Cloudesley Shovell in 1707. Salvaged from the bombed ruins with, it is said, the help of Sir Hedley Atkins, was an old round oak table bearing the carved initials of many Guy's men. This was given by the owners, Dick and Flossie Bones, to the Hospital and now resides in the Medical School.

Mr. W. E. Griffin, L.D.S., R.C.S., Centenarian this month

Dr. B. P. Griffin writes that his uncle, Mr. W. E. Griffin who qualified L.D.S., R.C.S., in 1901 celebrated his 100th birthday at Kite Hill Nursing Home, Isle of Wight, on the 16th of January. We offer Mr. Griffin our healthiest congratulations.

We should also like to extend our congratulations to Mr. R. W. Wilmott, B.Sc. (Hons.), B.D.S., L.D.S., on his appointment to Luton and Bedfordshire A.H.A. as a Community Dental Officer.

Dental Directory

A new edition of the Guy's Hospital Dental Directory has been printed and is available from the Sub-Dean of Dental Studies, Medical School, Guy's Hospital, London SE1 9RT. The cost including postage within the U.K. is £1.25. Cheques to be made payable to Guy's Hospital Medical School.

Copies will be available at the Annual Clinical Meeting on 3rd March, 1979.

Perhaps a start will now be made on a new Medical Directory? —Ed.

Past v. Present Hockey Match

This annual fixture will take place on Sunday, March 4th, at Honor Oak Park, bulley off at approximately 2.45 p.m. Would anyone who would like to play for the Past please contact Dr. Mike Appleby at 151 Chartridge Lane, Chesham, Bucks, HP5 2SE. Telephone Chesham 6407 (home) or Chesham 74855 (work).

Recent developments in the Hospital grounds

The two new **tennis courts** on the site adjacent to the Squash Courts should be ready for use by February, while the new studio accommodation has been occupied and Radio Guy's should be operational again by 20th January. The formal opening by David Jacobs will take place on Tuesday, 6th March, 1979.

Although remedial building work on **Bostock House** has been completed it has been necessary to add some additional alarm facilities to the new de-ionising plant. Provided that there are no undue delays to deliveries of equipment it should be possible to move the Intermittent Dialysis Unit back into Bostock House by the end of February.

As soon as I.D.U. moves back to Bostock House, work will commence to prepare **Sarah Ward** for use as a five day ward and this should be ready for use in April.

Plans have been approved for a new **Bloomfield Clinic** to be built in Great Maze Pond in the vicinity of the Post Room and Cylinder Store, work is due to commence in April and it will be necessary to move the Post Room and provide a temporary Cylinder Store. Proposals to build a new permanent Store to the west of the Squash Courts are being considered. The new clinic will take 9 months to build.

Accommodation for a new **Oncology Department** has been provided in the basement of New Guy's House where X-Ray Theatres used to be. Building work has been completed and this new Department should be ready by January, 1979.

Proposals are under discussion to build new accommodation for **Works Department** to replace that destroyed by fire last October.

Building work is underway to upgrade a further section of the old X-Ray Department on the ground floor of Hunts House to provide accommodation for the **Gastroenterology Department, ECG section** and a **Drugs/Poisons Information Unit.** This should all be in commission by July, 1979.

Tenders are due for return in the near future for the upgrading of **Old Barnabas Ward** into a Department of **Cardiology.** If tenders are within the sum allocated by the Region, building work should start in March. Tenders will shortly be invited by the Region for the conversion of the old **Caleb Diplock** on the 3rd floor of Hunts House into a **Stroke Rehabilitation ward.** It is hoped that building work can start in May. Work should also start soon on improvements to the Non-Sterile Manufacturing Laboratory in the **Pharmacy** to bring the area up to modern standards and meet the requirements of the Medicine Inspectorate.

Nos. 11–19 St. Thomas Street are owned by the Special Trustees of Guy's Hospital and building work has nearly finished on the restoration of these lovely Georgian houses as an office suite. The houses used to be the residences of Senior Staff (such as the Treasurer and Apothecary) of the old St. Thomas's Hospital when it was on that site. It is hoped that Guy's will lease these premises, in particular transferring over there the Community Staff currently housed at the Elephant and Castle in G.L.C. property.

Tenders have been received for work necessary to improve the access to the **Tunnel System** via the ramp at the east side of New Guy's House. It is expected that work will commence in a few weeks time and when this is completed it will enable the scheme for extending the **C.S.S.D.** to go ahead.

β-Pathy: a new disease?

Beatapathy is the synonym for Guy's Charities Week 1979, so called because it hopes to combat the torpor that becomes entrenched around this time of year.

Charities Week is from the 17th to the 24th of February and its aims are twofold:

1. To raise money for Charities within Guy's, locally and nationally, including Professor Polani's Paediatric Research Unit, Charterhouse-in-Southwark, The Spastics Society, The Spina Bifida Association and British Homes and Hospitals for Incurables. The accent is on children's charities as 1979 has been designated "International Year of the Child".

2. To promote communication inside Guy's, involving students of all disciplines.

This is the first time in recent years that such a venture has been planned for Guy's alone. It is hoped that, if successful, the Charities Week will become an annual event.

The suggested programme is,

Sat. 17 Valentines Disco and the selection of a "Charities Queen".
Sun. 18 Sponsored Bridges Walk.
Tues. 20 Real Ale Night.
Wed. 21 Barn Dance.
Thur. 22 Charity Lunch, Film or Quodlibet Event.
Fri. 23 Street Collection.
Sat. 24 Charities Ball.

This intensive course of entertainment hopes to raise a ripple of excitement during the three-month stretch of cold weather before the Easter holiday. Please come along, have a good time and help donate money to deserving causes!

Issues in Health Group

"In the Shadow of the Tower"

Problems of Health Care in Guy's District

In a district like Guy's, health care is dominated by the teaching hospital, even though the majority of patients are treated outside hospital. The I.H.G. have organised a series of meetings with speakers from local groups to discuss this and related problems.

7th February: *G.P. Services*
Introduced by Dr. M. Eisner, local G.P. Rosemary Hawley, C.H.C. member.*

14th February: *Guy's C.H.C.: What does it do?*
Introduced by Beryl Urqhart, C.H.C. Secretary.

7th March: *Community Action on Health*
Introduced by Jane Miller, Waterloo Community Health Project.
(*C.H.C. members are speaking in an individual capacity.)

The meetings start at 1.15 in the North Common Room, Boland House.

ALL students and health workers welcome

Guy's Hospital Rugby Club Reunion

A Dinner-Dance will be held in Boland House at 8.00 p.m., Saturday, 3rd February, 1979. Tickets £4.00 per head: contact Dr. T. Gibson, Dept. Rheumatology (Tel. Ext. 2424). The annual Past v. Present game will be held at Honor Oak Park, 2.30 p.m. on Sunday, 4th February.

Rugby Club First Fifteen Fixtures, 1979

Feb.	*3*	2.45 p.m.	Coventry	Coventry
	10	2.45 p.m.	Guildford and Godalming	H.O.P.
	17	2.45 p.m.	London Irish	The Avenue
	24	2.45 p.m.	Exeter	H.O.P.
Mar.	*3*	3.00 p.m.	Old Alleynians	Dulwich Common
	10	3.00 p.m.	Nuneaton	H.O.P.
	17	3.00 p.m.	Westcombe Park	H.O.P.
	24	3.00 p.m.	Cambridge City	H.O.P.
Apr.	*7*	3.00 p.m.	Old Whitgiftians	Croham Road

Second Fifteen Fixtures

Feb.	*10*	Guildford and Godalming	Away
	17	King's College	H.O.P.
	24	Old Citizens	Away
Mar.	*3*	Old Alleynians	H.O.P.
	10	Queen Elizabeth College	Away
	17	Law Society	H.O.P.

Please support our teams at these matches!

Hospital Blues and Half Blues

The Blues Committee have announced the following awards of Blues and Half Blues:

Cricket Club

Full Blue: Alasdair JACKS
Half Blue: Paul SHEPHERD
Richard SHERIDAN

Golf Club

Half Blue: Michael CRAIGEN
Stuart MATTHEWS
Guy PALMER

Lawn Tennis Club

Half Blue: Andrew MORGAN
Richard PLOWMAN
Tim THURSTON
Richard WELLINGTON

Swimming Club

Full Blue: Jon BEARD
David RICKARD

Guy's Hospital Dental Yorkshire Society

(Secretary: J. M. Colley)

The first meeting of the G.H.D.Y.S. took place on Thursday, 7th December, 1978 at Beadles Wine Bar. It was attended by 14 Yorkshiremen, representing all clinical years and three members of staff.

The evening commenced with the eating of traditional yorkshire puddings, followed by an excellent buffet. After dinner speeches were made by the society secretary, followed by Mr. N. Hunt, the president. This seemed to stimulate other members to take the floor, notably Dave Cheshire and Richard (Beaver) Nicholas.

The society hopes to meet again for a much larger society evening in March, 1979—and I hope that any freshers (or not so fresh by now) who are Yorkshiremen will contact me, c/o floor 24, Guy's Tower, as soon as possible.

South Wales and Monmouthshire Guy's Hospital Society

Chairman: Mr. G. Morwent Brown

Hon. Sec.: Mr. C. E. C. Lewis—"Dolwerdd"

10 Ger-y-Llan, St. Nicholas, Cardiff, CF5 6SY.

Tel.: Peterston-Super-Ely 760723 (Code 0446)

The 28th meeting and dinner of this society will be held at The Park Hotel, Cardiff on Saturday, 17th March, 1979, 7.45 for 8.30. Following the Wales v. England rugby international.

The President for 1979–80 will be Dr. M. E. Davies.

All Guy's men and women are welcome. The tickets for the dinner are £6.00 per head and the annual membership fee of the society £1.00.

It would facilitate arrangements if all those intending to be present would notify the Hon. Sec. and send their remittances, payable to the society, by Wednesday, 14th March, 1979.

Guy's Hospital West Somerset Bi-Annual Reunion Dinner

This will be held on Friday, 27th April in the Post-Graduate Centre, Musgrove Park Hospital, Taunton. Approximate cost £5.00 each exclusive of wines.

Replies to Dr. T. B. Pitts, Weaver's Mead, Curny Mallet, nr. Taunton, TA3 6SY (Hatch Beauchamp 480279).

Obituary

Dr. JAMES R. F. POPPLEWELL, M.R.C.S., L.R.C.P., D.R.C.O.G.

Dr. James Popplewell entered Guy's after leaving King's School, Canterbury with the reputation of being a good rugger player. He qualified in 1930 and became E.N.T. House Surgeon then R.O. before becoming R.M.O. at the Mayday Hospital, Croydon.

He began practice in 1932 at Whittlesey-Fens where he was a respected and well loved G.P. for 35 years: an extremely capable, understanding, happy man, devoted to his calling in a single-handed practice. He was appointed M.O. to the British Red Cross in 1933, and later when leaving Cambridgeshire was appointed M.O.H. to Hertfordshire.

He played rugger for Guy's 1st XV 1926–1932 and was captain two years in succession. An enthusiastic, bustling wing forward with a devastating tackle. A wise, kindly captain who brought out the best of his side by example and the splendid spirit of the game he infused into them. He was also a Kent County Cap and toured with the Barbarians.

Also he was a good light-heavyweight boxer with more than average skill.

Dr. "Pop" Popplewell
(see "A History of Guy's Hospital Rugby F.C. by Mr. T. L. T. Lewis")

He was a very keen gardener, with his favourite plants, orchids and cimbidiums, a good ornithologist and also enjoyed rough shooting over his farmer patients' fields. He was an expert judge of vintage port too.

He leaves his widow and two daughters and we extend our sympathy to them all. His first wife died in 1949.

C. D. M.

PERCY G. KING

Percy G. "Doc" King who died on 12th December, 1978, entered the employment of the Dental School on 12th May, 1919 as a "lab boy" and apart from two years which he spent as technician to Sir William Kelsey-Fry in his private practice, he remained in the School's employment until his retirement as Deputy Chief Technician on 30th April, 1969. He was seconded on a half-time basis to assist in the research into the use of Plaster of Paris in Dentistry which was carried out by the Dental Investigatory Committee of the Department of Scientific Research in 1925.

During the Second War he was evacuated with the Dental School to Tunbridge Wells where he was an active member of the Signal Section of the Home Guard and became attracted to the rural way of life. In his younger days he was a very good tennis player and he and his wife were accomplished exponents of ballroom dancing.

As a dental technician he was a great innovator and became an expert in the construction of artificial "eyes" used in the fabrication of maxillo-facial prostheses. He was a popular Undergraduate Instructor who will be remembered affectionately by the many generations of Guy's dentists who passed through his hands. We extend our sympathy to his widow.

D. J. Neill.

Mr. E. J. ("SAMMY") HALL

Many readers of the *Gazette,* particularly those of 1920—1960 vintage, will learn with regret of the recent passing of a familiar, loveable and most helpful character of their first days and years at Guy's, whether as Medical or Dental students.

"Sammy" Hall, as Laboratory Steward of the Biology Department both under T. J. Evans and later under Professor Foxen always got to know the new students and their needs far quicker than most, and would give practical help or, if needed, a word of friendly warning if he saw the red light flashing in any particular student's direction.

"Sam" belonged to the old School—Lab boy; Lab Technician; Lab Steward—performing his functions in his quiet inimitable way and it is for this he will surely be remembered.

Apart from his Departmental duties "Sam" also served his fellow Technicians both by running the Staff Canteen and in backing up the early efforts to help in Training Schemes for the I.M.L.T.

Owing to an unexpected deterioration in his health "Sam" was eventually advised to retire early and this he did moving from the London suburbs to more peaceful Sussex. Our sympathy goes out to his wife and her family whom he took under his care.

E. W. Baxter.

Mrs. M. H. STEVENSON-JONES, S.R.N., M.C.S.P. (Neé BRAYFORD)

Trained at Guys and remained to become a Staff Nurse before I whisked her into matrimony. Thereafter she worked as a Physiotherapist at Guys for a year until we moved out of London. She continued as a Physiotherapist until forced by ill health to retire last year.

Margaret died of cancer which was diagnosed and first treated by her "own" Guys unit at New Cross. She has always been intensely proud of Guys and was very impressed by the treatment she received.

R. S-J.

Review
Music Club Christmas Concert
HANDEL'S MESSIAH

An enthusiastic rendering of Handel's Messiah was heard by two separate audiences each packing Southwark Cathedral to capacity and more when Guy's Music Club gave their annual Christmas Concert on December 5th and 6th.

The choir was considerably larger than at their last concert and it was very pleasing to see a better balance between female and male voices.

Mr. Soothill is to be commended for his control over the choir who maintained freshness and clarity throughout the performance. In particular the sopranos excelled themselves with a unity that I have not heard before from a Guy's choir.

The soloists, Tamsin Dives (soprano), Julia Field (alto), Adam Skinner (tenor) and Sean Tighe (bass) were very good indeed, in particular Miss Field and Mr. Skinner gave thoroughly professional performances, their renderings of "He was despised" and "Comfort ye, my people" respectively were excellent. Mr. Tighe's "The trumpet shall sound" was also most enjoyable.

The orchestra, nearly all from Guy's, under Sue Jenkins has also improved greatly over the past year, their confidence rising as this performance proceeded. The strings, in particular the 'celli were good, and the violins made a very brave job of highly exposed passages in "Rejoice greatly, O daughter of Zion".

One cannot review a performance of Handel's Messiah without mentioning the "Hallelujah" chorus which was performed with great vigour and gusto, but which did not on the night that I was there stir the audience who stood rooted to the spot into voice despite an invitation. The final "Worthy is the Lamb" brought tears to ones eyes as it should!

In conclusion, the obvious enthusiasm and enjoyment of all of the performers under Mr. Soothill's able baton resulted in a most enjoyable evening for all, and I am sure we can look forward to further performances of this high standard in the future.

Alasdair Jacks.

Salad Days

Guy's Hospital Gilbert and Sullivan Society,
Greenwood Theatre, 13th–15th December, 1978.

What, one may ask, is the G and S Society doing performing modern works? The answer would seem to be thoroughly enjoying themselves and at the same time thoroughly entertaining their capacity audiences. The story line of Salad Days is no more far-fetched than many a Gilbertian libretto, and the simple melodies could be heard being hummed and whistled as the audiences left the theatre, and, no doubt, filled suburban bathrooms for many days after the performances. Salad Days has an advantage over most G and S in that, not only are the vocal rhythms memorable, but also those of the dance routines. It was only the most staid who could resist the urge to tap their feet, especially during the invocation to dance to the magic piano, around which the whole story is based.

There are 76 characters in this story, and one of the fascinations of this production was the way in which the 23 members of the cast shared these roles, some of them having six changes of costume and make-up. Adam Searle's production was slick and smooth and his choreography was well up to "Chorus Line" standards with some very professional touches. As he also appeared as Timothy the hero, his experience and vitality kept everyone else bubbling, especially his leading lady Margaret Foxton. She played the heroine Jane with clear, fresh tones which carried well across both the footlights of the Greenwood and the melifluous sounds of the musicians in the pit. The "orchestra" called for in this production consists of two pianos, whose ivories were triumphantly tickled by Richard Groves and Mike Lavelle, a battery of percussion, which was under the confident control of Dick Mallet, and a bass guitar, whose strings were veraciously vibrated by Mark Longden. For this production they provided the perfect combination.

There are no less than 19 scenes required, and these were smoothly slipped into position under the aegis of Paul Wooley as stage manager, and luminously lit by his lighting colleagues.

From a plethora of fine characterisations which this production provided, those by Peter Sanders were particularly outstanding. Bearded one moment, moustached the next, he moved from the "paternal" to

the "diplomatic" and from the "theatrical" to the "scientific" with consummate ease. Other quick change artists whose performances will linger in the memory for many a year include: Mike Fillery, no bishop will ever dare to dance again!—Gillian Smith, forewarned is four-armed, even in gold lame tights; Martin Colley, an inspector after the heart of Clouseau; Amanda Smith, "weedkiller" one minute, cat burglar the next; Chris Allen, rarely recognised but always good value on stage, whether as Lord Danvers or as the "Chaplinesque" Fosdyke; Elizabeth Friend, from the youth of a nun to the senility of Aunt Prue; Alan Watson, who was always the part, and they were many, including dons, school children, Americans, Ambrose (the designer at Gusset Creations), or as Augustine Williams, the outwardly austere Minister of Pleasure and Pastime, and Kay Worrell, who can forget her Asphinxia?

Other members of the chorus, whose contributions were, without exception wholly credible, were Clare Allen, Jane Christie, Pippa Pigot, Gary Creswell and Catherine Tanguy. Not everyone was called upon to change character every other scene, and amongst those who gave star performances were: David Hett, as the tramp (Uncle Ba Ba, the black sheep of the family); Jayne Owen, as Timothy's mother; Vincent Barrett, now becoming type-cast, as Boot the policeman; Susan Moore, as Jane's mother, how she managed to carry on speaking whilst being beautified with cream and powder, without sneezing, was a mystery; Shiras Gulamali, as Troppo, the silent one; Juliet Dowler, as Rowena, the belle of Gusset Creations, and Nicholas Chandler as the thought-transferring Electrode.

One of the most memorable songs in the show was "We said we'd never look back", however, it will be entirely with pleasure and pride that those who took part in this production, whether on or behind the stage, in the pit or in the box office, or even the paying audiences, will look back on the Salad Days of '78.

David Brown.

Dental Review 1978

"A Shot in the Bum"

Once again the final year students combined to entertain all their friends and to entertain and tease members of the Dental School Staff. It is difficult to understand how they can do it; one week they are engaged in the wholly absorbing business of sitting finals, facing examiners and having their dental knowledge probed; the next week they are performing a complicated pantomime, review or whatever it was as a final offering to their *Alma Mater.* They played to a packed audience in the Greenwood Theatre on the Monday before Christmas.

The reviewer could not discern a central plot to this year's production and in spite of there being a well produced programme this was remarkably uninformative. It did not contain information about the locations of the scenes, the characters or the cast. The audience had to work extremely hard to decide which department was being portrayed, then to identify the characters as well as listening to the script which was sometimes delivered at high speed. Inevitably a percentage of the audience were left rather confused.

The first scene showed some of the day work in the Periodontal Department. As might have been expected there was a strong Naval atmosphere—one of the patients being an Admiral friend of a member of the senior staff.

The sketch about the technicians showed the Sargeant Major Chief Technician drilling his troops and reminding them of their job descriptions. These were listed as:

1. To drink tea and hold union meetings.
2. To increase Hospital inefficiency.
3. To annoy and frustrate students—this could be accomplished by having the radio on the most nauseating station available, hiding the demonstration models and disappearing for a tea break if a student wished to ask a question. Other useful tips were given such as prolonged reading of newspapers and lengthy phone calls. The reviewer assumes that this sketch was based entirely on fictitious characters although the programme stated that "any likeness to any persons, living, dead or otherwise, is completely deliberate".

One of the highlights of the first act was a simple little song about the use of dental floss. This was sung by what must have been the No. 1 pin up girl of the final year, dressed as a bunny girl, complete with fish net tights. The use of floss silk was described in great detail although teeth were not mentioned at all. Her actions and sultry voice imparted a completely new dimension to flossing and she almost brought the house down.

Act 1 concluded with a sketch entitled "The good, the bad and the satisfactory" and featured many of the staff of the Prosthetics and Conservation Departments in a cow boy war between the de Trey boys from the crossed Baseplate Ranch and the Amalgam bunch. There was a great deal of shooting, noise and much bloodshed. In the end nearly everybody was killed whilst the ladies in the compound went on knitting!

After the interval the action moved to the Primary Treatment Unit where the "Oddfather" arrived with toothache—there was no mistaking the Senior D.S.A. who greeted him, nor the member of staff who investigated the problem and proceeded to do multiple extractions. One of the best songs in the show was sung to the accompaniment of their guitars by Martin Delahaye and Rick Rome—a most professional performance. It went like this:

"Down here in P.T.U. they've got themselves a plan,
They spell out all the words in case the patients understand
Like T.C.A. in one/fifty two and nasty N.S.U.
We thought you'd like to know they've got the students confused too . . .

Chorus
Oh Mrs C.L.A.R.E. is running after me,
My G.A. patient's just arrived by car and drinking T.
The D.S.A.s are all at lunch and I am all at C.
Oh P.T.U. makes me sick of dentistry.

There was a man with A.U.G. was looking for P.D.
He got sent up to P.T.U. quite accidentally,
So we slapped on the T.C.A. as usual liberally,
You heard his screams in L.A., G.A. and C.S.S.D.

A girl came in with A.O.B. increasing her V.D.
Her O.P.G. was N.A.D. her P.A. and A.P.
But A.O.B. had somehow got changed to S.B.E.
So we took down her P.D.H. and stuck in some Pen V.

The audience quickly picked up the chorus and sang it with enthusiasm.

The scene then changed to show some "Germs" trying unsuccessfully to attack the enamel of an outsize molar tooth which it transpired had been treated with fluoride. Eventually it was decided to dynamite the tooth but before this could be done one of the bacteria collapsed and died after drinking chlorhexidine. We were then astonished to see a very female spermatozoan rushing across the stage desperately looking for an egg! Further confusion followed as the Gestapo like vaccine squad appeared. The dictatorial captain insisted on examining the explosive charges and succeeded in detonating them and killing everybody.

The final scene "Peter in Pantoland" was in the Children's Department where we were surprised to learn that bitter rivalry existed between the Orthodontists and Paedodontists. Peter, a school boy, was obsessed with drilling holes and it was decided he should go to the school in the sky where he could give full expression to this hobby. On the way to the Tower Peter met Dobbin the horse who was having private orthodontic treatment from one of the consultants. During the sketch the Emperor of the Department was wheeled on desperately trying to keep peace since the deanery election results had not been published. The scene ended with Dobbin "pouring contempt" on the Producer who was winding up the show. The final song was sung by the entire cast and possibly did not really reflect their attitude to the Dental School.

There's no dentures like Guy's dentures,
Like no dentures we know.
Wearing them is really rather galling,
Gums are erythematous and raw.
Everything about them is appalling
They're always falling upon the floor.
There's no fillings like Guy's fillings,
Like no fillings we know.
Polishing is always done with gumption,
Centric bite is always premature
Gives the patient T.M.J. dysfunction
So that their munching is rather poor.
There's no students like Guy's students,
Like no students we know.
We never really wanted to be dentists at all,
But since we've been here we've all been having a ball,
You've all been trying to teach us things we don't just recall
And now that we are through . . .
We DON'T know what to do!!!!

Congratulations are due to all those who took part and especially to Francis Hughes the producer. This very brief review cannot possibly convey to the reader the brilliance and subtleties contained in the script or the trouble some of the performers had taken to study their "doubles". The entertainment was thoroughly enjoyed by all as was proven by the

number of curtain calls at the end of the last Act. The final year then invited members of the staff to a splendid buffet supper in the East Wing.

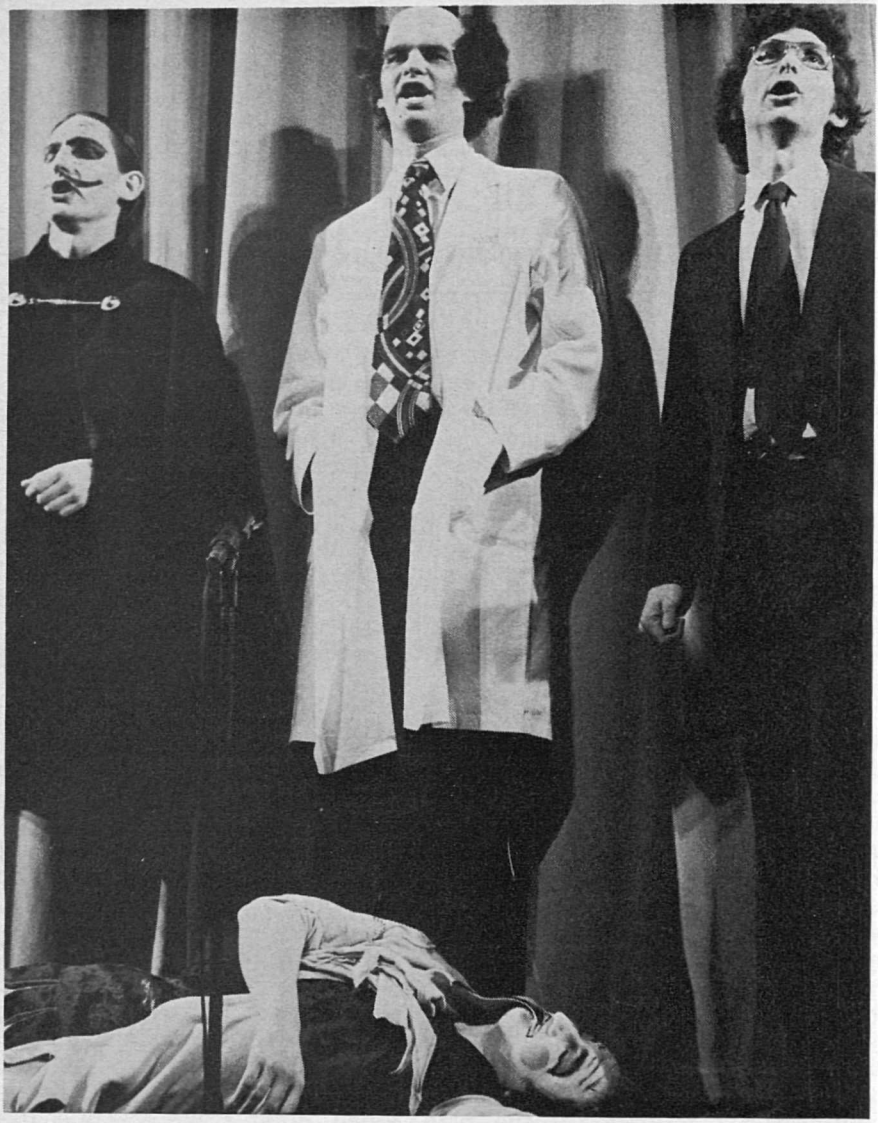
A. H. R. Rowe.

Residents' Play 1978

Knight Fever—A Christmas pantomime of mediaeval fayre

The Residents' Play is clearly one of the highlights of the year at Guy's and it is astonishing how each year the necessary ingredients of wit, talent, music and imagination are found and brewed into a presentable and enjoyable performance. The 1978 production was no exception and, although I believe that there were problems right up to the dress rehearsal and even on the first night, the second night was virtually flawless. We had $2\frac{1}{2}$ hours of great fun, as much for the players it seemed as for the audience, and it was at least up to the standard of the two previous productions (the only ones that I as a "new boy" have seen). I am sure that Christmas is the ideal time for the play and was surprised at the timing of the two previous ones. A pantomime offers relatively limited scope in some ways, but it worked this time.

The story featured Robin Hood, given a splendid straight performance by the shapely Anne Nixon, and his quest for the hand of Maid Marion, played most engagingly by the almost equally shapely and very convincing John Twomey. This was a curious inversion of normal panto theory, with the male impersonation of the nubile maid rather than the ugly sister or equivalent. Still he (she) did it very well indeed and, I'm told, grew into the role magnificently. The opponent of the match was one of the two villains of the piece, Sheriff Coiner of Nuffingham, Maid Marion's father. He was played with a haughty and imperious disdain by John Ethimiou, who had obviously studied his subject well. I know that there have been many previous portrayals of this particular subject and I regret that I cannot make comparisons, but this one impressed me greatly. The Sheriff's two aims were to establish a private hospice in Greenwood Forest and to wed his daughter to the noble Knight of Kent. The Knight was heard offstage only towards the end of the play, when Robin's merry colleagues arranged a quick ambush and substituted Robin for the Knight. Robin then claimed Marion's hand successfully from the unwitting Sheriff. This was the only disappointment. We were all expecting to see the Knight make his grand appearance. We heard that he was "fair of hair, blue of eye, little of figure" but . . . he did not appear; only his voice was heard briefly and then extinguished. A pity, especially as he had given his name to the title but perhaps he is not an easy subject to portray (although I would have guessed differently).



"It was alright on the knight"

This is a bare outline of the plot. The play started with a long and menacing prologue by the other and greater villain Dand Anals (Nigel Womack), who explained how he despised everyone in the story. He appeared later, somewhat out of context, to lead the whole ensemble in a stunning display of punk rock which almost brought the house down. Fantastic energy and he gave a repeat performance.

After the prologue, many of the rest of the cast appeared as Robin's jolly men who entered singing a rousing and tuneful number:—

We are the Greenwood men, Southwark's lads in green
Each one has the strength of ten men, and the strongest staff
you've seen.

Their leader was a splendid take-off in the shape (literally) of Alan A'Bates and here I must devote some space to Jon Ayres. Not only did he write much or most of the play, as he has done for the last two years, but he also played the part of Alan (on account of David Skinner's illness—at least on the second night). This was a swash-buckling performance, which delighted us all and was a marvellous caricature. He described life at Russell Brook thus:—

No-one comes to my patch, not even vegetations,
General surgeons who encroach risk verbal lacerations
Now that poor old Donald's gone, I'm the Lord and Master.

Alan appeared repeatedly during the play and gave Robin all the encouragement he needed.

The next scene concerned one, Max Riddle, played convincingly by Roger Atkins. He got the voice well and sang a witty song about problem orientation, but it was all a bit of an aside and did not contribute to the story. Riddle appeared later in the punk rock, also with great verve, and seemed happier in that than in his song. A funnier aside followed and we met the Good Fairy, who was given a superb performance by William Suddell. The fairy could hardly control her mirth and I found her irresistable. She encountered a personable young farmer/vet called Rectally Geared (Stephen Forsdick), who was carrying a huge instrument with which to examine an errant cow. This was an excuse for the (to me) most engaging and distinctive song of the show: it captured the mannerisms to perfection even if he didn't really have the physical shape.

The refrain after each verse was done splendidly, the music was full of lilt and charm and the lyric was cleverly written.

The rest of the first act was concerned with Sheriff Coiner, constantly berating his unfortunate Jester (Tim Bayliss) and generally bringing us all to order. The Sheriff's song contained gems such as:

I grew so wise in the charging of a fee, etc. 1 verse.

Act Two began with the Gay Forresters and their Comely Wenches and soon we were engulfed in punk rock, shortly followed by an amiable duet sung by Friar McTuck (Clive Archer) and Red Scarlet (John Britton). This was the classic physician versus surgeon dialogue, but they both joined forces to round on the common enemy, Dand Anals. We all knew who McTuck was, although he appeared a little bland to me, but Red Scarlet was splendidly Irish and unmistakable:

Physician and surgeon should be friends
to end.

"Merrie Men of the Forest"

The music for this duet was especially appealing.

Next we met Maid Marion in the Forest and found Dand Anals trying to impress her (in French!) in a cunning and malevolent way. Red Scarlet hurried on, concerned for her, and warned her of the man-eating plant which threatened them all. Now here was the phenomenon of the show. Nigel Bardsley sang a song, which had nothing to do with medicine or Guy's and had no tune but which was embellished by castanets in the form of dentures. This stopped the show several times and I had to check hard that it had no other significance—just an entertaining personality and a great idea, which really came off.

We moved back to Sheriff Coiner's castle and there was a long scene, in which Maid Marion pleaded her love for Robin Hood and was told firmly that she must have the Knight. She sang a mock Elizabethan lament:

My father would have me
To wed a fair Knight,
Alas Alack, Alas Alack.

The Good Fairy appeared and promised to help—for a fee!

Back in the Forest, Robin was being encouraged by an agreeable and vigorous Scot (Steven Watson)—a somewhat salacious character with a twinkle in his eye, a firm white moustache and a very thick accent. He fooled me for a long time, but I suppose it was obvious to many that he represented an important establishment figure. In Jocking aside he revealed himself:

with the splendid refrain—

For I'm good with a glove . . . round in the bar.

This was the most extreme caricature of the show, perhaps excessively so, but it was an inoffensive and affectionate portrayal.

The final scene opened in the Castle with a sad Marion about to meet her Knight and the Good Fairy attempting to comfort her. The two sang a Drag Duet with all the right gestures, whimperings and purrings.

Following this the guests were announced as they arrived for the wedding party. I must admit that the repeated medical punning of their names palled a little and this could (in a long show) have been omitted, but I don't wish to introduce too critical a comment. The rest of the play was over quite quickly with the Knight ambushed and Friar McTuck hastily marrying Robin and Marion, while Dand Anals tired to tell the Sheriff that he had been hoodwinked. At the very end Coiner rounded on Anals and encouraged the boys to throw him to the mercy of the man-eating plant—and all ended happily.

In this review I can only indicate the highlights and give the essence of the story. Many people were responsible for making it a success. The music of Mike Lavelle and his colleagues was especially praiseworthy and at times quite arresting in its physical impact and, at other times, in its melodiousness. The scenery, art work and wardrobe were all of a high standard, but I cannot refer to all responsible by name.

In short, I enjoyed this play very much and I know that the audience as a whole did. I have every reason to believe that the cast loved it—it is such a shame that all the hard work and fun was over so quickly. I congratulate them all and look forward to next year's play with confident expectations.

Gordon Sladen.

A History of Guy's Hospital Rugby Football Club – 3

by Mr. T. L. T. LEWIS

The Churn*

*See Mr. Winston's article, *Gazette*, Vol. 82, 1968, p. 617.

It was on Thursday, March 12th, 1908, that an event of great historical importance to Guy's took place. As the train from Waterloo to Richmond, crammed full with Guy's supporters on their way to the Cup match with the London, halted for a while at Vauxhall Station, a milk churn was "acquired" which has been the supporters' mascot from that day to this and is paraded at every cup final in which Guy's appears. The ringleaders in this exploit are said to have been N. S. H. Warner, R. Crowle (both dental), and A. C. Hancock.

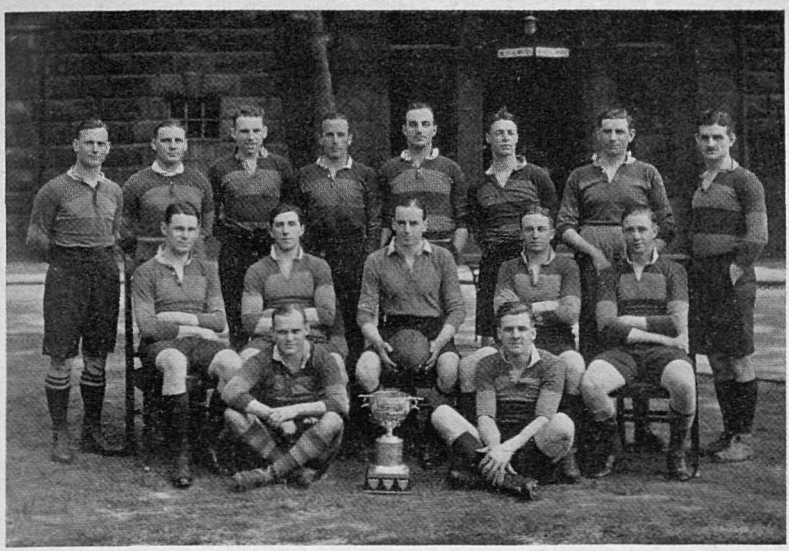
In 1908 the team maintained its high standard, fielding four Internationals, J. P. Jones (Wales), Harry Lee (England), H. Archer (England) and G. R. Hind (England).

Much of the success of the team was due to the superb play of Jones who made many beautiful openings for A. L. Stokes, son of the famous "Lennie" Stokes of the seventies. Both Stokes and L. B. Stringer, an England reserve, scored many fine tries during the season. C. S. Lane-Roberts, also reserve for England, W. S. Stranack and G. R. Hind, who subsequently got their English caps, and H. R. Mullins were prominent in the pack. Five Guy's players were chosen for the Anglo-Welsh team to visit Australia, Jones, Archer, Hind, W. Morgan and P. F. McEvedy, who was vice-captain of the touring side. Guy's played 20 matches and won 14; they also regained the Cup, in the presence of H.R.H. The Prince of Wales. The next two years, with H. R. Mullins captain in 1909–10 and G. R. Hind (a superb hooker) captain in 1910–11, were equally successful and the Cup was retained. R. S. Kennedy, a Cambridge Blue, was unable to get into the first team at the beginning of the season, but his remarkably close dribbling due, he said, to his short-sight which prevented him from seeing the ball if it got more than a yard away, soon gained him a place. The captain in 1911–12 was C. H. Medlock, a brilliant outside-half. This was the first season at Guy's of Harry Millett, who was to play full-back for England after the war. On the small side, he played the game of his life for London against the South Africans in 1912; his fielding of a wet ball, kicking and tackling were largely the cause of the South African defeat. Three other Guy's men played in this game, A. L. Stokes, R. S. Kennedy and G. R. Hind, whose hooking time and again deprived the South Africans of the ball.

A new outside-half, L. R. Broster, an Oxford Blue from Grahamstown, South Africa, joined Guy's early in 1913, in time to help them beat London in the cup final; later in the year another South African, S. S. L. Steyn, a flying wing-three-quarter of Diocesan College, Rondebosch, came down from Oxford, but this year, the last before the war, the Cup was lost. Steyn played for Scotland. Later he, O. Parry-Jones, A. L. Liebson and E. F. Llavena were killed in action.

Rugby during the First World War

At the outbreak of the war sporting activities at Guy's were suspended. A few games were played each year from 1915, mainly against service sides. F. A. Knott, later bacteriologist to the hospital, was a dashing wing-three-quarter; a South African, F. W. Reitz, showed how versatile he was by playing anywhere on the field. The games were arranged by C. L. Curle, helped by C. H. Medlock and Harry Millett, returned from Gallipoli. Others playing by 1918 included F. Bekker and C. Bekker, P. Krige, J. A. Currie, W. H. Cellier and J. Van der Merwe, all South Africans, D. J. P. (Pat) O'Meara, who was also captain of soccer, A. H. Shelswell and G. B. Dowling, later on the consultant staff of St. Thomas's.



Season 1921–22

E. S. Neser. F. J. Biddle. E. H. Fouraker. W. H. Taylor.
P. G. Harvey. C. L. Steyn. G. Zondagh. L. K. Watson.
R. F. H. Duncan. P. K. Albertijn. W. D. Doherty (Captain).
J. G. Van-Schalkwijk. F. W. Bekker E. L. Sprong. A. K. Van-Niekerk.

The Brightest Years

The four years after the war 1919–1923 were undoubtedly the brightest in the whole history of Guy's rugby. For three of them the side was captained by the greatest leader of forwards the hospital has ever had, W. D. Doherty ("Doggie" as he was known then, or "George" later). He returned from the war to play in a few games at the end of the 1918–19 season, and then took over the captaincy of the team. In one season he was captain of Ireland, Surrey, United Hospitals and the greatest ever of Guy's sides. It is said that his cry of "Tally Ho!" or chastisement for a forward who was slow on the loose ball could be heard clearly in the stand from anywhere on the field. What is more important, his leadership brought about the desired results. For this due credit must be given to all those who responded so well to his driving personality. Doherty himself regarded the 1921-22 team as the best and I give the Cup side in full: A. K. Van Niekerk, A. B. Daneel, P. K. Albertijn, J. G. Van Schalkwijk, C. L. Steyn, E. L. Sprong, F. W. Bekker, E. H. Fouraker, G. Zondagh, E. E. Neser, W. H. Taylor, L. K. Watson, F. J. Biddle, P. G. Harvey, W. D. Doherty (captain). (R. F. H. Duncan, a regular member of the team, could not play owing to the proximity of the International.)

The results for the four years are also worth recording:

Season	Played	Won	Drawn	Lost	Cup
1919–20	29	23	–	6	Won
1920–21	27	19	2	6	Won
1921–22	35	26	2	7	Won
1922–23	32	19	4	9	Won

The season 1919–20 blazed the trail for what was to follow. Harry Millett was full-back and was capped for England. His place, later in the season, was taken by W. J. Olivier. The brothers Krige, J. A. and P. J., were in the three-quarter line and J. A. played for England against Wales. There was so much adverse criticism in the Press against the England selectors for choosing a South African that no more were selected in the next few years, although there is no doubt that several deserved to be. This caused considerable comment at Guy's because the selectors seemed to have no hesitation in selecting Australians and New Zealanders. The prejudice came to a head in 1921–22 when an Englishman with a South African name was passed over for a trial by the selectors for a South African with an English name, although everyone at Guy's knew that the Englishman was the better of the two! W. D. Doherty played for Ireland and H. Graham-Davies was prevented from playing for Wales by a leg injury, although selected. He was capped the following year. C. L. Steyn, on the wing, was a great athlete. Given a chance with the line in front of him, he was through in a flash and his speed made him virtually unstoppable. He could run a hundred yards in ten seconds, and in the Inter-Hospital Sports won the 100, 220 and 440 yards and the long jump. He also broke the Guy's record for the 220 and long jump. The halves were plucky and resourceful, Frans Bekker and J. Van Schalkwijk ("Goldflake" or "Goldie" as he came to be widely known). These two were regarded by many as being every bit as good as the famous English pair, Davies and Kershaw. They played together for the South against England but the prejudice against playing South Africans prevented greater honours coming their way. The pack was one of the biggest for many years and very speedy, with E. E. Neser, H. Van Zyl, C. Marais and F. W. Reitz, all South Africans. R. F. H. Duncan later played for England three times. G. E. Kidman and A. H. Shelswell (hooker) made up the eight.

Crowds at H.O.P.

Outstanding wins were against Oxford University 24 points to 3, the United Services 11 points to 3, Coventry 26 points to 10 and the London Scottish 34 points to nil. The Cup was won in a stirring game against Bart's by 6 points to nil in the presence of His Majesty the King, to whom the teams were presented before the game. Guy's success drew great crowds to Honor Oak Park and spectators were often turned away. To make sure of a seat in the stand, one had to be there three-quarters of an hour before the kick-off.

In 1920–21 the side was joined by P. K. Albertijn from South Africa. He was a truly magnificent centre, fast running, swerving, handing-off and selling his famous "dummy". He was also a sure tackler. His build, his pace and his cleverness made him one of the greatest three-quarters of all time, certainly the best in England for two or three seasons. It was the firm belief at Guy's that had his name been Smith he would not have been omitted from the England side. However, he had to wait until 1924 for International honours and it was with some quiet amusement that Guy's took note of the fact that the captain of the Springboks, who twice beat the British Touring team in the Tests in South Africa, was none other than their own P.K.

Other newcomers were W. H. "Bill" Taylor, a hard and strong forward of international class, captain of Cornwall and reserve many

times for England; and A. Daneel, full-back or three-quarter. The outsides Krige, Albertijn, Graham-Davies, Steyn, Bekker and Van Schalkwijk had tremendous scoring power, and in the season they piled up 602 points with only 96 against them. Wins were recorded against Gloucester, Oxford University, the London Welsh and the London Scottish among many others. On more than one occasion every man outside the scrum was South African. H. Van Heerden played full-back, Daneel, Albertijn, Krige (J. A.) and Reitz at three-quarter and Bekker and Van Schalkwijk the halves.

The Cup was won against Bart's 3 points to nil, with J. A. Krige crocked early in the game.

W. D. Doherty

Doherty was captain again in 1921–22 when the fixture list was one of the longest ever, including matches against most of the leading clubs in the country. E. L. Sprong, another South African with very safe hands and an elusive run, came in at stand-off half to partner Frans Bekker, and Van Schalkwijk moved out to the centre with P. K. Albertijn. Daneel and Steyn played on the wings. Great crowds continued to flock to Honor Oak Park and a new stand was erected. E. J. (Charlie) Crisp (later in charge of the Department of Physical Medicine at Guy's) played full-back a few times. F. Biddle, E. H. Fouraker, L. K. Watson and G. Zondagh (hooker) established themselves in the scrum with E. E. Neser, W. H. Taylor and P. G. Harvey, R. F. H. Duncan and W. D. Doherty. The strength of Guy's was shown at Cardiff Arms Park, where they beat Cardiff 10 points to 8 before a crowd of 10,000 without the services of five regular players. E. J. Crisp played full-back and the deputies were A. Hirschberg on the wing and R. V. Cookes, N. M. Holloway and E. G. Hutchinson in the forwards. Only seven games out of 35 were lost and no London club defeated Guy's during the whole season, while 467 points were scored against 162.

Cup Rag, 1922

The Cup was won in an extraordinary fashion, Guy's beating the London by 42 points to 6. The game was preceded by one of the most hilarious rags ever and in the midst of it all the King arrived. "The revellers immediately surrounded His Majesty, hats and caps were doffed, cheers and shouts rent the air till suddenly a transformation took place, somebody started the National Anthem which was taken up by everyone on the ground." These were three great seasons for W. D. Doherty, who was to succeed A. R. Thompson as genito-urinary surgeon to the Hospital and later to become a great Medical Superintendent of Guy's.

P. K. Albertijn took over as captain in 1922–23 and Frans Bekker, vice-captain. Nine of the old star players had to be replaced. It is to the credit of the Junior teams that their places were satisfactorily filled by men such as S. R. Trick, G. R. Mostert, H. Finnemore, G. G. Cameron, N. M. Holloway, B. G. Scholefield, and G. Fellowes-Smith. Nineteen matches were won out of 32 fixtures.

The South Africans

There were now so many South Africans at Guy's that the committee, thinking that they would not be happy over the festive season

unless they were playing their favourite game, arranged a Christmas tour for them in France. They drew with the Stade Francais and the Stade Poiteain. "Le Petit Parisien" said that the Guy's team "furnished a remarkable game, all the players handling excellently and introducing all kinds of variations into their play". In particular, the French singled out for praise, Albertijn, Mostert, Steyn and Van Schalkwijk. The Cup was won against Bart's 3—0 after a grim struggle. Albertijn was tackled hard twice early in the game. He was knocked unconscious the first time, returned and was carried off soon after. There was no score until four minutes from the end, when Frans Bekker hurled himself over for the winning try. The following day Albertijn departed for South Africa at the completion of his course. Guy's were sorry to lose such a charming personality against whom an unkind word was never said.

After four such successful seasons a lesser one was bound to come and it fell to the lot of J. Van Schalkwijk to spend the 1923–24 season training the new blood. Of twenty-seven games played, thirteen were won, eleven lost and three drawn; points for 285 and against 151. We lost the Cup in the semi-final 6—0 to Bart's. Of the newcomers, P. D. B. Spence, a South African Davis Cup tennis player, was a great asset at full-back which position he shared with W. J. Badenhorst; John Durr, late captain of Edinburgh University, and W. ("Pop") Myburgh, an excellent hooker from Cape Town University, both also South Africans, arrived late in the season.

Late 1920's

Although there were several good forwards in N. M. Holloway, B. G. Scholefield, E. H. Fouraker, G. G. Cameron, J. W. Schabort, G. G. T. Tregarthen, H. de Wet Vorster, E. W. Hutchinson and Eric Neser, the scrum never got going properly. As a result, three-quarters such as Steyn, Fellowes-Smith, Graham-Davies, Finnemore and G. Mostert did not do themselves justice. Van Schalkwijk captained the team again in 1924–25. He himself played centre and V. Preen took over at stand-off with W. Meissner or W. Hops as scrum-half. Most of the previous season's forwards were available and great wins were obtained over Gloucester (5—0), the Harlequins with Wakefield, Marshall, Davies and Brodie (16—0), London Scottish (16—0), London Welsh (3—0) and Blackheath (6—0). J. R. F. Popplewell arrived during the season and established himself in the side. Graham-Davies, after a lapse of four years was picked again for Wales. So high was the standard of rugby at Guy's that there were times when even he had difficulty in gaining his place in the 1st XV and often he had to play out of position on the wing in favour of one of the skilful South Africans. In the Cup we drew 3—3 with King's in the semi-final. They had three Internationals in the scrum, W. R. F. Collis (Ireland), R. Cove-Smith (England) and D. J. MacMyn (Scotland). Fortunately Collis missed an easy convert which would have given King's the match. In the replay the right wing of Graham-Davies and Fellowes-Smith were in tremendous form, scoring three tries, and Guy's won 14—3. In the final Guy's beat the London 7—0, a fitting tribute to "Goldie" the captain of his team of eleven South Africans, three Englishmen and a Welshman!

John Durr was a splendid captain in the less successful season of 1925–26. Fourteen games were won out of twenty-nine and good wins were obtained against Coventry, Blackheath, the Royal Air Force and

Cambridge University. Among the forwards Nils Eckhoff (later Surgeon to the Hospital) played occasionally and G. G. Cameron, E. W. Hutchinson, W. H. Myburgh, J. R. F. Popplewell, C. Kurtz, J. W. Schabort, J. H. Cullinan, J. Visser and W. Radford played regularly. Outside, J. Van Schalkwijk was still playing and the others were chosen from G. Fellowes-Smith, F. H. B. Spence (Hector was a brother of Pat), C. L. Steyn, G. Mostert and G. Clarke. At scrum-half there was either T. O. Garland, W. D. G. Jones or W. Hops, who also played in the scrum. P. D. B. Spence was full-back or stand-off half, in which event his place was taken by V. G. Boyle. We lost the cup final to St. Thomas's 5—0 (the first win by St. Thomas's since 1897). Van Schalkwijk was off the field for most of the game and St. Thomas's exploited the situation with high kicks to the full-back F. H. B. Spence (his brother Pat having gone to stand-off). A storm of protest followed the usual cup final rag and there was a strong attempt to dispense with it altogether because of damage to property and annoyance to the public. For the first time Guy's entered a team for the Middlesex County Seven-a-Sides competition and did well to be beaten in the semi-final by Blackheath 6—3.

End of an Era

The season 1926–27 saw the final break-up of the famous 1920–24 teams. Van Schalkwijk, Fellowes-Smith and Steyn all left Guy's. Dr. John Fawcett, who had been President since 1912 after Sir Frederick Taylor handed over to Mr. F. J. Steward. G. G. Cameron was elected captain and he led his pack with enthusiasm and inspiration. Of thirty-four matches played, eighteen were won, including games against United Services, Portsmouth, Birkenhead Park, Bedford and Plymouth Albion. We won the cup, beating King's 10—0 in the final. Playing full-back was V. G. Boyle; on the wings, G. J. Clarke and A. J. D. Lewis; in the centre, H. F. Wilkinson and F. H. B. Spence; at half-back, Victor Preen and Tommy Garland, or W. D. G. Jones. At forward, Pop Myburgh was a top-class hooker and the rest of the pack consisted of C. D. (Pat) Malone, J. Durr, J. W. Schabort, J. H. Richmond, J. H. Cullinan, A. Simpson-Smith, L. Brown, D. S. Clogg, T. Morgan, J. D. Radford, and J. R. F. Popplewell, who was in the Kent side that defeated Hampshire in the County Championship. E. W. Hutchinson, an old Guy's man, was also in the Kent side.

To be continued next month.

DANGER MEN AT WORK!

Some Occupational Hazards of Team Work in General Practice

By Dr. D. G. Craig, M.A., B.M., D.M.J.
Gallions Reach Health Centre

For decades family doctors have worked in isolation. It is likely that a process of self-selection directed certain personality types into the

work. The personal continuing nature of the one-to-one contact, and the entrepreneurial pleasure of having no obvious master must have encouraged both individual excellence and individual waywardness. Man and wife and dog sometime come to resemble each other, and it is tempting to match some patients with some doctors. Looking at one's own patients, this comparison seems neither so relevant nor very flattering! Anyway, a *modus vivendi* was often negotiated, whereby the patient accepted certain limited skills, and the doctor accepted certain personality failings.

The grow of group practice and the efflorescence of health centres have produced a new working environment. Peer review has become both a possibility and a threat and the ability to work with other professionals now seems as important as in hospital and factory. Twenty or more professionals may be working together. The majority may be women who share the dual agony of home versus work and the common experience of the pre-menstrual state. The doctor may be the oldest person in the team, and also the one likely to stay the longest. As a result of a piecemeal amalgam of allowances and item of service payment, he will be the best paid, which he may feel reflects his longer working hours and his legal responsibilities. He may properly resent that he is the only person who has to be bright and cheery after a night on duty and somehow never enjoys "days in lieu". He may have transformed a rapid rate of work into a self perpetuating treadmill, and may equate his breezy manner with a wholesome breath of fresh air, and will resent having his opinion questioned. He is used to taking decisions in the presence of uncertainty, and may be impatient of those who counsel reflection and information gathering. Others may wish leadership upon him: he will have no training in management and may not have an appropriate temperament to acquire such skills. The male doctor and his pronoun have crept into this paragraph. The female doctor may be spared the strident stirrings of the feminist movement, but she cannot escape the dilemma of leadership in a participatory democracy. She can be a closer sister to the staff in some ways, but may find the translation into the leadership role every bit as difficult. She may turn one cheek only to find her own flank turned!

Colleagues have managers who sometimes provide them with official deputies and sometimes spirit them away unannounced on baleful courses. Outside the primary health care team there are meetings of nurses and partners which can easily be seen as threatening and excluding cabals. Properly these people try to display loyalty to two teams but cannot share the doctors entrepreneurial zeal. The payments by item of service, which are truly an important fragment of the doctors total remuneration, are seen as anachronisms. The staff do not fail to observe the paradox that it is the Community Nursing Sister who performs the immunisations, and the Community Midwife who gives the ante-natal care.

In this new world the doctor is looking for a new style of leadership. He will be navigating in stormy waters. To his bewilderment the majority of his colleagues will be resistant to change. The doctor who thought himself conservative and middle aged will seem surprisingly malleable by comparison. It is trite but true to observe that all the professionals except the doctor have prior experience of the doctor/patient relation-

ship. These role models date from a childhood experience of 10-15 years ago and can typecast a doctor who is himself wide open to change. The imaginary stereotype can affect the attitudes and relationships of staff members as much as it undoubtedly conditions patient expectations. It is quite likely that team members themselves share the same mistaken attitudes expressed in the phrase "there must be something you can do for a cold".

The doctor will probably alternate between two styles of management reflecting, as is natural, his own life situation. The weak disciplinarian with outbursts of heavy handedness may disconcertingly become the sycophantic lover expressing gratitude and sickly charm. Accurate analysis of conflict will be interpreted as a policy of divide and rule. His best ideas will suffer initial rebuff and when adopted are no longer attributed to him. He must certainly bear the ambivalence of leadership. Success brings plaudits; failure brickbats. His very praise can be partisan and divisive, and by silence he can imply disregard and contempt.

As the group grows in size he must wrestle with the problems of group dynamics and mutating roles as the small group loses its initial family cosiness. The encouragement of smaller group meetings may only mimic the formation of teams at a Christmas party, whereby a few disconcerting isolates are ignored. Even so beer and circuses and team games have a part to play. The caring professions need to set a better example, and lunch time tennis among team members, or a jocular jog through the woods may speak to the community better than pious sermons about exercise. The concern for morale needs to be as traditional as a good battalion commander, but deployed a good deal more subtly.

A philosophy must be developed which accepts that containment and contentment are proper functions of leadership. A standard must be unfurled which satisfies the customer without allowing an endless escalation of demand. A caring sympathetic attitude among the staff must be fostered. Non-structured agenda-less meetings occurring off the health centre premises can be a weekly safety valve. A practical demonstration of democracy is a reception-counter rota involving all personnel, so that everyone can attend such meetings. The existence of several loyalties must be accepted: they parallel the loyalty to hobby, relaxation, and family and need careful negotiation.

The doctor must try to afford equal dignity and respect to the allied (erstwhile ancillary) professions, but must sometimes find this difficult. The importance of the work is too easily called in question if it can revert to the unskilled doctor at 5 p.m. He must face the undoubted conflict between the curative and preventative roles. The well baby clinic must be afforded equal importance with consulting sessions and student teaching. It must not be the automatic sacrificial victim at times of timetable stress.

A proper recognition of the equal worth of receptionists, clerk, telephonists and secretaries needs some physical expression. They share the patients' confidence; they should be seen to enjoy ours. Their presence at information meetings and retreats is a step in the right direction.

An attempt can be made to involve the local community in their responsibility for providing and apportioning health care. At one extreme

is the model of a complaints post box—at the other a doctor and nurse adulation society. Ready access and the lack of obvious hierarchy brings its own strains. Patients and staff alike can be differential consumers of doctors' time and love. A new relationship with a new breed of health centre manager may be needed. What is our responsibility for disciplining and containing those people in our midst who seem to consume an unfair proportion of the health centre's time and energy? If the occasional patient and staff member could be persuaded to experience a half day in reception a dialogue might be started. "How hard the receptionists work" might be a starting point for other speculations. "What would we prefer the team to do for us. If they give more contraceptive advice it might have to be at the expense of ——."

Like the much maligned and misunderstood Machiavelli, the doctor must believe in the ability of a leader possessed of "virtu"—excellence of character—to discern rules of behaviour based on a knowledge of how men and women do in fact behave, rather than consideration of how they ought to behave. The doctor must begin to think that his teaching/learning role is as important with the staff as with students and patients. He may well have to write a set of objectives, devise a teaching programme, and attempt to evaluate its success.

"Issues in General Practice" Contributions should be sent to The Editor, Guy's Gazette, 16 St. Thomas' Street, SE1 9RT.

The Epidemiology of Anorexia Nervosa

by JUSTIN McARTHUR

It seems that Anorexia Nervosa (AN) is becoming more common, even taking into account increased medical and public awareness of the condition. In the last few years several case register studies have revealed an increased incidence amongst clinic groups, but these can only represent a minority of cases. It is a potentially crippling disorder with a significant mortality from inanition and suicide, and the differential diagnosis is very complicated, including depression, schizophrenia and organic disease.

The term Anorexia Nervosa was originally applied by William Gull in 1874[1] to "a peculiar form of disease" occurring mainly in young girls, characterized by refusal to eat and extreme emaciation, which he attributed to "a morbid mental state". Though doubts have been expressed about its status as a disease entity, it is generally regarded as a consistent syndrome. It is typically seen in adolescent girls, although an onset up to the mid-thirties is recognized, and a similar syndrome can rarely occur in children and in males.

Three essential criteria are now accepted by most investigators: (1) active food refusal leading to weight loss; (2) amenorrhoea, usually preceding any weight loss; (3) a phobia of becoming fat with disturbances of body image.

Other features commonly seen are hyperactivity, self-induced or automatic vomiting, purging or excessive use of diuretics and a complete lack of sexual interest. Physical signs of starvation develop and are similar to those seen in food starvation, there may be hypotension, bradycardia, pallor, constipation and changes in hair, skin and nails. Metabolic changes can be detected—disturbances in hormone levels and thermoregulation.[2]

The aetiology is as yet unknown. In 1914 Simmonds found at autopsy that an emaciated woman had post-partum destruction of her pituitary gland and for the next 20 years AN was frequently misdiagnosed as Simmond's disease. Psychodynamic factors were popular like Waller's "Oral Impregnation Theory", which he proposed in 1940 —he considered that it was "the wish to be impregnated through the mouth which results at times in compulsive eating and at other times in guilt and consequent rejection of food". The many psychological approaches have been unhelpful and inconclusive and now attention has swung to the hypothalamus as a possible factor in the causation of AN. There is now considerable evidence of hypothalamic dysfunction, including endocrine, water conservation and the thermoregulation studies. However it is still not known whether these changes are primary to the development of AN or only appear after years of weight loss.

Thus AN still remains an unknown and indeed mystifying condition with very few clues as to what causes it and so how best to treat it.

Prevalence and Incidence

Public knowledge of this disease has greatly increased over the last few years and indeed only a few months ago questions were asked in Parliament expressing concern at the apparent increased incidence of the condition. The following mortality figures were produced by the Minister of Health[3] as evidence that there was no such increase.

Deaths from Anorexia Nervosa (total p.a.)	1973	26
	1974	26
	1975	23
	1976	24
	1977	21

A letter from A. H. Crisp[4] in response to these figures reveals several interesting points. Crisp states that the figures are misleading for several reasons. Firstly deaths from AN usually occur after several years of illness and a recent rise in incidence would not immediately influence mortality rates. Secondly, deaths in AN are frequently not recorded as AN, suicide being the commonest cause of death. In Crisp's view the problem has become much greater in the last few years because the actual incidence has increased.

Exactly how prevalent is AN therefore, and what factors lead to its development? Findings of prevalence studies may be complicated by several factors. Firstly many people with the disorder actively avoid medical attention even when severely disabled. Secondly the differential diagnosis is very complex. Finally can studies performed at different centres with different populations be compared?

The largest and most recent study was published by Crisp *et al*[5] in 1976. During 1972-74 nine populations of school-girls were surveyed

for AN. Previous school years going back 3-6 years were also studied. In this study it was found that AN was relatively common in the independent sector of education, and this was attributed to a social class factor, there being a preponderance of SE groups I and II in the independent sector. In school-girls aged 16-18 the prevalence in private schools was 1:100, in comprehensive schools 1:330 and overall 1:200.

The second prevalence study was conducted by Kendell *et al*[6] from data obtained from psychiatric case registers in NE Scotland, Camberwell in SE London and Monroe County in New York State. The following results were obtained over periods of about 10 years:

NE Scotland: total population 473,370 in 1966
average annual incidence 1.6 per 100,000
annual sex-age specific rate (15-34 y) 10.8 per 100,000

A greater proportion were in SE grps. II and III but only in the same proportions as the general population.

Monroe County: total population 586,000 (25,000 negroes)
av. ann. incidence 0.37 per 100,000
ann. sex-age specific rate 0.8 per 100,000

Camberwell: total population 172,000 (10,000 immigrants)
av. ann. incidence 0.66 per 100,000
sex-age specific rate 4.1 per 100,000

There was an excess of patients with parents in SE groups I and II.

This study aimed to show that AN is more common in the "middle classes" but rare in negroes. Also that it is increasing in frequency, however the numbers of patients were relatively small compared with the other studies, and the differences reported may not represent significant differences.

The final study I shall use to illustrate the prevalence of AN comes from Theander in Sweden.[7] Over a 30 year period he calculated an av. ann. incidence of 0.24 per 100,000. Interestingly the figures rose to 0.45 per 100,000 in the last 10 years perhaps indicating a rise in incidence.

Prognostic and Predisposing Factors

There are certain risk factors which can be identified to help define an at-risk group. As has been seen already the peak incidence is between 15 and 34 years, and particularly 16-18 year old girls. Crisp has identified several other factors which can affect the likelihood of developing AN, and also affect its prognosis.

Certain features of the upbringing of anorexics seem more common:[8]

(1) a higher birth weight compared with non-anorexics;
(2) breast feeding;
(3) childhood obesity;
(4) an early menarche. Crisp postulates that this premature demand for sexual adjustment, in combination with an immature personality, precipitates the condition;
(5) obsessionality in the family, particularly about diets or food.

Contrary to popular belief the risk of AN does not seem to be increased with dieting. Although most patients with AN have dieted during their

adolescence, dieting is such a common phenomenon amongst teenagers that it cannot be thought of as a true risk factor.

Once AN has developed there are certain features which have been described by Crisp[9] which can affect the long term outcome.

(1) Gender: AN is infrequent in males (perhaps 1:15) and they probably only develop it in the context of overwhelming psychopathology or massive obesity. Male anorexics therefore have a worse prognosis.

(2) Social class: AN is more common amongst SE groups I and II, and these groups also have the best prognosis. It is interesting to note that obesity is generally more common amongst working class families.

(3) The age of onset is important in predicting outcome. A late onset (in the third decade) correlates with a poor prognosis. Early onset patients also do badly, especially if they have been obese. It is important to note that it is often difficult to determine a precise age of onset in someone who has been anorexic for many years. Usually the onset of ammenorrhoea is taken as the start of the condition.

(4) Family nutritional characteristics can influence the course of AN. There is often a history of weight disorders—either obesity, food fads or AN—in the families of anorexics who respond poorly to treatment. If the patient is obese premorbidly this is another indication of a poor response.

(5) Marriage and its role in AN are poorly understood. Anorexics are generally sexually inactive and a change in libido on recovery can alter the relations between husband and wife. Conversely anorexics who marry subsequently improve in terms of eating patterns and may even become pregnant.

(6) Many investigators claim it is impossible to alter the chronic nature of the disease once it has become established for more than 10 years. Chronicity is also associated with other poor risk factors such as bulimia, vomiting and purging.

(7) The premorbid personality has been investigated in great depth, without, however, much agreement between workers. Generally the child has had few behaviour problems and neurotic problems tend to worsen the prognosis dramatically. Undue rigidity in the family or patient tends to make any treatment difficult.

(8) Finally a distorted body image, for example a grossly exaggerated estimate of body width, means that the long term prognosis is very poor.

Treatment of the condition is initially life-saving. Tube feeding and IV nutrition have fallen from favour and present policy is to use a modified behaviour regime with goals defined by patient and therapist. This may be supplemented by phenothiazines and psychotherapy. Other investigators have used ECT, L Dopa[10] and even metoclopramide,[9] with varying degrees of success.

Reported prognosis varies from 35-80% recovery,[10] probably due to differences in selection of cases and length of follow-up. In one study of 41 patients seen 3-10 years after admission, 60% still showed some form of eating disturbance, 50% remained underweight or showed great fluctuations in weight.

Summary

To summarize therefore: the prevalence of AN amongst 16-18 year old schoolgirls is overall 1:200,[8] the figures from various studies being reasonably comparable. A poor outcome is associated with being male, SE group IV and V, late onset of disease, excessive weight disorder and a preoccupation with fatness. Other factors which affect the prognosis include a long duration of illness, high levels of rigidity or depression in the families, bulimia, vomiting and purging. It seems that the prevalence of AN has truly increased over the last few years, although further studies need to be done to confirm this. It is hoped that a wider knowledge of the risk factors will enable those who deal with young girls at the "dangerous age" to make the diagnosis earlier. There is evidence that early treatment can stop the progression of the disease which has a relatively high mortality of up to 15%.[10]

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Quodlibet Society

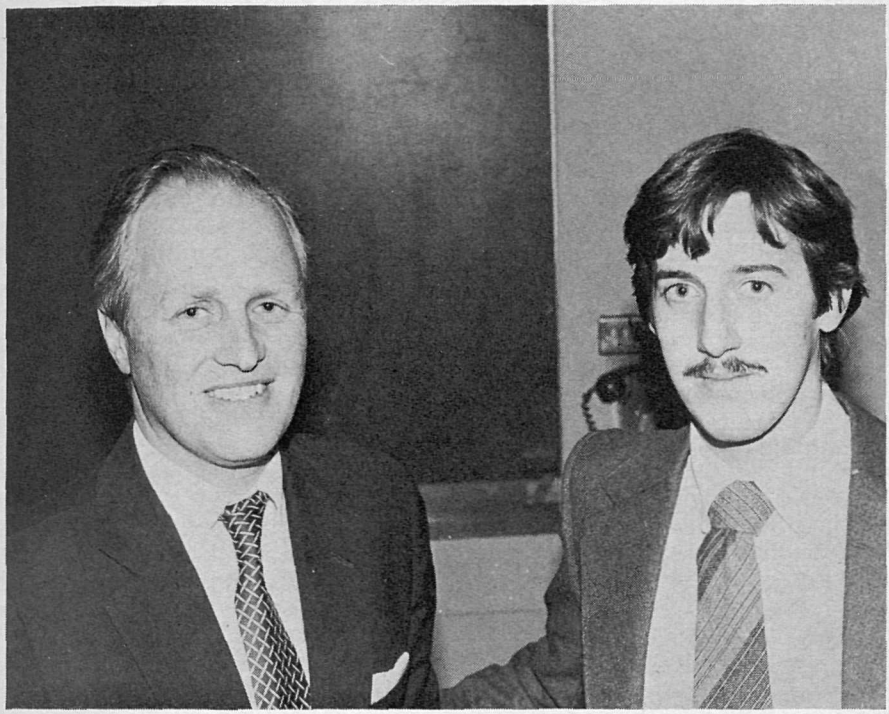
Quod Libet Society Meeting, December 6th
"Challenges to Peace and Freedom"
Winston Churchill, M.P.

This was the last meeting of the Quod Libet Society for 1978, and rounded off perhaps the best year since the society was revived in 1975.

From the outset Winston Churchill, grandson of the famous Winston and recently sacked as Shadow Minister of State for Defence, made it clear that there is only one serious challenge to peace and freedom and that is the Soviet Union. He then proceeded to explain why Russia (the same thing really) must be regarded as the potential aggressor.

After the Second World War had ended the Soviet Union had annexed the East European countries and needed to rebuild its army in order to defend their newly acquired subjugate states. Indeed its army has been called on twice, first during the Budapest uprising in

1956 and again during the Prague uprising in 1968, when tanks were sent into these cities in order to retain Russian "imperialist alien control", as Mr. Churchill described it. However with the West's acceptance of the status quo in Eastern Europe Mr. Churchill believes that the Soviet Union was then able to adopt expansionist policies. Leonid Brezhnev himself stated that so-called *Détent* should not affect wars of "national liberation" which put another way means that *détente* will not stop the Soviet Union aspiring to rule 3rd World countries. Mr.



Mr. Churchill with Richard Trembath, Quodlibet Chairman

Churchill quoted as an example the recent war between Ethiopia and Somalia. After the overthrow of Haile Selassie in Ethiopia Russia found herself supplying arms to both arch enemys. Siad Barré in Somalia disapproved of this and threw the Russians out and in the war that followed Russia poured into Ethiopia more tanks than Britain has on the Rhine—Somalia has a population of only 3 million. After an interview with President Siad Barré, Mr. Churchill was convinced that the Soviet Union intended to subjugate large areas of Africa, in much the same way as it did in South East Asia. Control of Ethiopia would give the Russians an ideal position from which to move on Sudan, which they have attempted twice before, and from there to Egypt in the north and Kenya to the south.

However grave these developments might be Mr. Churchill believes that Russian expansionist policies are ultimately directed against what he describes as the "powerhouses of Western democracies". These are the oilfields of Saudi Arabia and Iran (witness recent developments), and the mineral quaries of central and southern Africa. Two countries concerned in this latter category are Angola and Rhodesia which he said are being destroyed by Russia. After all, "how can a two bit banana and tobacco chewing republic in Central America invade Africa without Russian help"? In passing, he was also sharply critical of the way Dr. David Owen (a past speaker to the Quod Libet Society) and Andrew Young had handled recent developments in these two countries, Dr. Owen for his rigid stand on the make-up of the new security forces in Rhodesia, and Andrew Young for his outbursts on human rights, notably in Angola.

From what Mr. Churchill said it seemed that the Soviet Union would steamroller on until it achieved world domination. But there is hope. Some African countries, Kenya, Sudan and Zambia for example, realise what the Russians are after and are now exerting pressure on their neighbours to dissociate themselves from the Soviet sphere of influence. Mr. Churchill had hope that this trend would continue.

Finally he stressed that the sheer volume of military hardware that the Soviets are massing during the "so-called era of *détente*" posed a threat to all of us. Why, he asked, were they producing as many as a thousand Hiroshima-sized bombs per week, and as many tanks as Britain has on the Rhine every nine weeks? With this in mind one is forced to agree with Mr. Churchill's closing sentence, "We live in a dangerous world".

Jonathan Barker.

Nursing

The recently published report of an investigation into the conditions which existed in a hospital for long stay patients, has been very widely publicised. The facts which were revealed are very disconcerting and should surely cause members of the nursing profession to consider anew their methods of practice.

One alarming fact that emerged was the lack of competence of the senior members of nursing staff in the hospital. In fact, recommendations were made that a number of these people should be dismissed.

Any nurse who has concern for the welfare of her patients, must certainly now be giving thought to the question of how such incompetence is allowed to exist, and how such people manage to obtain their posts, and also, who appoints them? Furthermore, how widespread is such inefficiency and how much is being concealed?

Nurses constantly claim that they should be regarded as professional people, it must however, be extremely difficult for the general public to adopt such an attitude, when it is revealed that even the most senior officers are incapable of fulfilling their duties.

The roles of all nurses, but in particular those of senior members of the profession, have changed dramatically in recent years. Many individuals have resented this, and, whilst wanting recognition as a profession, are unwilling to accept the inherent responsibilities. This has caused their refusal to adapt to the demands of present day hospital administration and their subsequent inability.

Unfortunately, there is a misconception amongst nurses that the promotion of those who are inadequate, will solve the problem of their inability to meet the demands of their work. The truth of the matter is, that efficient organisation is disseminated downwards from the most senior officers. Thus, when those who are ineffective reach the top of the pyramid, the result of their inability will affect all employees.

It is sobering to think that such situations do exist within the Health Service, but maybe nurses may now be prompted to reflect seriously on the methods by which our hospitals are managed.

Pam Jeffries.

Physiotherapy

Shortly before Christmas, the King's Fund Centre held a conference on Aspects of Multidisciplinary Management and Education, based on the Middlesex Hospital's two and a half week teaching block for medical, nursing and physiotherapy students in the Geriatric Unit and on ward meetings at the West Middlesex Hospital, which, frankly, looked like anybody else's case conferences except that these had been recorded on video. One of the most eloquent platform speakers was a medical student, obviously wholeheartedly into the multidisciplinary thing, and it was evident that she felt she had learned a great deal from the different attitudes and approaches of the nurses and physiotherapists, this having been enhanced by the problem-solving method used by their teachers. Reference was made to the amount of teaching that ward sisters handed out to young doctors, and somebody made a rather obscure remark about learning in contrast to teaching, and how difficult it all is to organise and then we all went home.

If that sounds supercilious, it is the result of disappointment rather than cynicism. Physiotherapy students are quite fortunate, really, in the course they follow—they have their three week nursing period (as radiographers do) during which they gain some insight into the nurse's role. They receive a series of lectures from physicians and surgeons, from other paramedical professionals and from the clinical staff of the associated departments. They go on ward-rounds and hear other points of view expressed, and they may even have their own view-point sought. Nurse students perhaps do even better on the clinical lecture side, but appear to have only fleeting opportunities to learn much about what others (physiotherapists anyway) hope to contribute to the welfare of their patients. However, they are made aware of the existence of other people in the team.

For a while, it seemed as if it might be possible to extend this illumination to medical students as well. That may be rather unkind, and even unjust, but it was a pity that the attempt to bring paramedical staff into the team-teaching groups was not persisted with. It is obviously true that a future doctor needs to learn a great deal about esoteric factors which will guide him to a diagnosis, but he could perhaps benefit from the more simplistic analysis of, for example, the therapist, whose questions, basically, are what can you not do that you would like to or should be able to do, and what can I do to help you do it? Perhaps the answers will be everything, and nothing, but at least a direct remedy has been sought, and this might be the difference the Middlesex student found, the difference between the complicated, the involved, the learned—and the simple and direct.

It would be naive to contend that such straightforward answers can always be found, but often something can be done, and it might be refreshing for the medical student to consider, if only briefly, what alternative therapeutic avenues are there to be explored.

Ronald Cooper.

Book Reviews

"Children and Youth. Psychosocial Development", by Evans and McCandless. Pp. 568. Price £8.50. Published by Saunders, 1978.

Like many American text books this one is clear and organises the knowledge in a logical way. A vast amount of research data is quoted which is presented in a sound scientific way with summaries at the end of each chapter.

Not only does the work provide an over view of psychosocial development, but it also has an excellent appendix of almost 40 pages summarising the major theories of development. The social aspects are particularly stressed which is unusual in this type of book. Unfortunately not all the social influences are relevant to this country so it is necessary to maintain a proper perspective when reading.

Americanisms such as "Religiosity", and "Followership" crop up now and then which might annoy some readers and enhance others. Photographs and case examples enliven the text—e.g. Middle Class Joanie, aged 10 years describing how she would deal with cheating: "It depends who it is . . . nobody rats on friends but if it was Ransall I might tell . . . he is such a fink nobody likes him"!

Any student of human nature will find this book useful as a general book and it should be available in every library dealing with the human sciences.

J. B. PEARCE,
Consultant, Dept. of Psychiatry.

"Adolescent Dermatology", Ed. L. M. Solomon, N. B. Esterly, E. D. Leoffel. Pp. 485. Price £25.75. Published by Saunders, 1978.

This book is a new edition to a series of monographs entitled "Major problems in Clinical Paediatrics". Two of the editors, Drs. Solomon and Esterly, had previously contributed this book's partner in the series on neonatal dermatology. Whereas "Neonatal Dermatology" was one of few books to tackle this particular field, "Adolescent Dermatology" tends to cover ground dealt with satisfactorily in a number of other books. Although there is a definite emphasis on dermatological problems encountered in adolescents, the subject matter differs little from that of any good general dermatology textbook. On the other hand, this volume does not attempt to be a comprehensive textbook, but singles out areas of special importance in this age group, such as acne vulgaris.

This is generally a well written book, attractively presented and easy to read, though it is not especially well illustrated. Its content is too basic for dermatologists,

but it would be ideal for the interested paediatrician, though I imagine the publishers had a wider readership in mind. It is not entirely clear to me at what particular audience it is aimed; at £25.75 it is expensive and could hardly be recommended as a book for every undergraduate's bookshelf.

DAVID J. ATHERTON,
Senior Registrar, Dept. of Dermatology.

"Renal Histopathology", by Robert Meadows. Pp. 554. Price £30.00. 2nd edition. Published by Oxford University Press.

The second edition of this book contains the same very high standard of presentation of light microscopy of renal histopathology. In addition there is now quite a lot of immunofluorescence data and some relevant electron microscopy. The book is a formal account of the subject but is somewhat repetitious. The references quoted appear to have been read carefully but there is little discussion of the problems raised.

One cannot help admiring the presentation of this book which is very attractive. The size of the book is rather greater than its real content since some of the text lacks precision, and a smaller version would presumably have been both cheaper and lighter to carry.

I suspect that it will be purchased by the majority of those persons who need to interpret renal biopsy material and that it will tend to be a book kept on the shelf rather than one that is used frequently.

D. R. TURNER,
Reader, Dept. of Pathology.

"Clinical Pharmacology", by P. Turner and A. Richens. Pp. 254. Price £2.95. 3rd Edition. Published by Churchill Livingstone, 1978.

Clinical Pharmacology now stands on its own as a separate part of the final M.B., B.S. examination and has equal weight to medicine, surgery and obstetrics and gynaecology. It is therefore not surprising that this excellent paperback has now gone into its 3rd edition. Even though I would recommend "Clinical Pharmacology" to undergraduate medical students, the book is more than a collection of facts about drugs to be learned for an exam. It is in fact a remarkably clear and authoritative summary of the use of drugs in contemporary therapeutics. The authors are distinguished pharmacologists and have made individual contributions in the fields of centrally acting drugs and cardiovascular therapy. Every word they write speaks of their considerable clinical and scientific experience.

The basic aspects of the subject—such as clinical trials and pharmocokinetics—are dealt with briefly and elegantly. A very wide range of topics is covered, including much of the recent work on psychotropic and vasoactive drugs. There is also a useful summary of the use of drugs in tropical diseases.

This book will be invaluable to anyone who is concerned with the drug treatment of patients—including those learning about therapeutics for the first time and also more senior doctors who want to keep up to date.

ROY SPECTOR,
Professor, Dept. of Pharmacology.

"Current Paediatric Therapy 8", by S. Gellis and B. Kagan. Pp. 879. Price £23.00. Published by Saunders, 1978.

The compilers say that this book attempts to provide its readers with the information they want in the way they want it. They have produced a very comprehensive book, including topics some may never have thought of as problems or as having a place in this book, e.g. "Unusually Tall Stature in Adolescent Girls", and here as in other sections such as those on Sudden Infant Death and Accidents the book usefully underlines how broad the concept of therapy should be. Nevertheless, it occurs to me that the book fails in its attempts to provide a comprehensive review of its chosen subjects. It is often too brief, too dogmatic, and makes too much seem too simple, e.g. Exstrophy of the bladder, not pointing out where there is major conflict of opinion, or persisting uncertainty as to the "best" therapy. This gap could have been filled for the postgraduate student by a short list of references, but very few are provided. It is also a little behind the times with respect to investigations and (inevitably) some drug therapy, a fault which could have been rectified in the same way.

The reviews seem to have been aimed more at American "Office" practitioners, yet they too might well be frustrated, as would our Casualty Officers or General Practice trainees, if they sought a readily available, logical, basic outline of first line management. This is often there, but has to be extracted from the too comprehensive text.

The section on nappy rash "Eruptions in the Diaper Area" (sic!) provides a good example of how the succinct advice one would seek is hidden in the last five

lines, when the first five paragraphs would defer you from ever reaching them! These lines on "the essence of treatment . . .", should surely be at the beginning, and the reminder that it may eventually be necessary to rule out systemic diseases such as syphilis, acrodermatitis, entropathica, and Letterer-Siewe disease should clearly be at the end and not in the first paragraph.

Chronic problems are not dealt with any better, but the book is useful for the range of subjects discussed and for going on into the field of caring for adolescents e.g. reminding one that the I.U.D. is safer than the pill for hypertensive girls when British Physicians rarely seem to consider that there'll be any need at all for such a consideration.

This also leads into the frequently raised need for written informed consent for therapy, but one of the longest sections of the book is taken up with explaining just what informed consent is (or seems to be).

There is, however, a great deal of useful information and ideas in this book, yet there is nothing that is not better dealt with elsewhere, and would make it a desirable book to buy. It comes nowhere near the standard of A Textbook of Medical Treatment by Alstead-Girdwood which most usefully complements Davidson's Principles and Practice of Medicine. One's money (£23) would be better spent on a full textbook i.e. Nelson, Vaughan, McKay (£10.50) and even more so if put towards the 2nd edition of Forfar & Arneil's Textbook of Paediatrics (£50).

HOWARD BLUETT.
Sen. Registrar, Dept. Paediatrics.

"The Use of Drugs in Psychiatry", by J. Crammer, B. Barraclough, and B. Heine. Pp. 230. Price £3.95. Published by Gaskell Books, 1978.

This is an extremely sensible, straightforward and practical book. It assumes, quite correctly, that the brand new psychiatric SHO knows virtually nothing about psychotropic drugs or even psychiatric illness.

In the introduction, relevant pharmacological concepts are clearly explained under no-nonsense titles such as "How Drugs Reach The Brain" and "Drugs In The Brain". In addition one is given a great deal of practical advice about prescribing, including the correct way to write up a prescription and what factors are pertinent to the evaluation of a drug trial.

The "Notes On Management" are also full of good sense with concise and unbiased descriptions of all the major psychiatric illnesses in terms of aetiology, presentation and symptomatology. The aims of drug treatment in all cases are clearly defined and the guidelines laid down for the rational prescription of drugs are obviously based on many years of clinical experience.

The second half of the book is basically a drug list. Virtually all regularly prescribed psychotropic drugs are included, with information regarding indications and use, side effects, contra-indications and interactions and presentation. Also useful is an appendix on "How To Give Electroconvulsive Therapy" which should allay apprehensions and dispel misconceptions for doctors required to carry out this often emotive manoeuvre.

The book itself is small, suitable for the pocket of a white coat (except that psychiatric SHO's don't wear them for some obscure reason) with an anonymous white cover, allowing it to be referred to surreptitiously on wards rounds, in front of Sister or even in front of patients without destroying your credibility. One eccentric feature is the inclusion of a number of blank pages, headed "notes", after each section. I had previously regarded this as a device designed to use up spare pages in the back of schoolboy diaries.

I would consider this book invaluable for any doctor beginning his training in psychiatry and for anyone else involved in the care of psychiatric patients. Inside my copy is a small announcement that the book may be purchased by mail order for £2.95. On the back cover it is priced at £3.95. This was the only inconsistency I could find.

T. R. E. BARNES.

"Atlas of Clinical Anatomy", by R. S. Snell. Artist: Terry Dolan. Pp. XI + 530, 401 Illustrations. Price $24.95. Published by Little, Brown and Company, Boston.

The author of this new atlas is Professor Richard Snell (Geo. Washington Univ. Sch. of Med., Wash., D.C.), who has already published a textbook for dissection and a "clinical" textbook of anatomy, with both of which this atlas is expected to "key". The arrangement is regional, therefore, and there are eight sections: Thorax (38), Abdomen (50), Pelvis (22), Perineum (20), Arm (72), Leg (71), Head and Neck (84), and

Back (24). This departs little from customary corporal partition, except in the separate section for the back. The figures in parentheses denote the number of illustrations for each "part", and it is immediately obvious that Professor Snell has not cut back much on the limbs, which might have been expected of a modern, "clinical" textbook. Each section begins with a series of photographs (50 in all) to show, in somewhat unappetizing colour, the surface of the human form in all its particulars, a useful feature in this age of "permissiveness" and yet startling ignorance of the "form divine" (the models chosen are suitably "mortal"—and the female indeed looks seriously ill). The photographs are, in themselves excellent and are the work of Mr. James Kenrick. All the remaining 351 illustrations (many of which are in fact multiple) are by Mrs. Terry Dolan. These are clear and adequate; those concerning bones are good, the rest are perhaps a little crude. The colours used will not be to everybody's taste, muscles and fat being shown in particularly garish tones. However, this is not an important criticism, being merely a personal predilection. The illustrators have together carried out their commission. It is perhaps a little more doubtful how far Professor Snell has succeeded in his "clinical" selection. All textbooks of anatomy are "clinical", "medical", "applied"—or whatever qualifying adjectives one cares to add to the simple word "anatomy", because *all* such books contain some or much (according to their size) that is medically relevant. The difficulty lies in discriminating, selecting and emphasizing—against the ever-present dangers of omission. It is an almost impossible task, because it is played out against the hectic tempo of a world festinantly pursuing "progress", by which is meant materialistic profitability. "Relevance" is the rake constantly dragged through an ever-widening field, in which "subjects" pullulate like industrial estates, and no one has much time for anything. Professor Snell has my sympathies in the dilemma of what to give the impatient student, who is allowed scant time for this most basic of medical studies, compressed between computer lectures on homosexuality or community care. In solving the dilemma the author has been somewhat conservative, for which I at least applaud him. It is, nevertheless, disturbing to find no charts of cutaneous innervation or lymphatic drainage, no *visual* coverage of muscle or joint activity. In fact normal function is neglected, except in brief textual comment. Perhaps one should recall that this atlas is to be used with Professor Snell's textbook (and dissecting manual), but collectively this entails much more than a thousand pages to encompass in grossly overstretched time-tables.

The clinical "sauce" is scattered somewhat erratically over the supposedly indigestible meal of simple anatomy, and the attempts to integrate anatomy with function (rarely attempted) and pathology (more usual) are of very mixed quality. It is not helpful to be informed that, in the foot, "the main use of the interossei is in walking"! Many of the clinical allusions, also, are parallel to the anatomy rather than integrated with it. Nevertheless, the book has its qualities, and so—*chacun à son goût!*

ROGER WARWICK,
Professor, Department of Anatomy.

"Gynecologic Cytopathology"—A Colour Atlas of Differential Diagnosis", by Marie Luise Schneider and Hans-Joachim Staemmler. Pp. 179. Price £24.50. Published by Saunders, 1977.

This is a beautifully illustrated atlas of gynaecological cytology with helpful diagrammatic guides alongside each of the superbly reproduced photomicrographs to aid identification of individual cells. The text is not much more than an introduction to the accompanying pictures but the book is well organised and easy to follow. The authors reveal a depth of experience in the subject and this is most clearly shown by the imaginative attempt to give a differential diagnostic summary in the areas of greatest interpretative difficulty. In part this has led to oversimplification with, for example, an emphasis being placed on the numbers of abnormal cells present in a smear being a reflection of the degree of epithelial abnormality. Smears of carcinoma in situ are said to contain more than 500 abnormal cells. If this was the case the task of the screener would be greatly facilitated! In fact the number of abnormal cells reflects the extent rather than the severity of the lesion and the effectiveness of the scrape.

The scope of this book is not comprehensive or well enough balanced to be of value to those with no practical knowledge of the subject, but is a useful addition to the library of those with some cytological experience.

JOYCE VALE,
Clinical Cytologist, Guy's Hospital.

Correspondence

Gray's Anatomy—A Warning

Sir,

Some of your readers may have observed that the London Bridge Branch of W. H. Smith is exhibiting for sale what is described on the dustjacket as "The Classic Collector's Edition" of Gray's Anatomy. It is also described in a book-sellers blurb as "A revised version of the authoritative English 15th editon. An international bestseller for over 100 years, its appeal is not only to physicians and students, but also to artists and the medically inquisitive."

The book is indeed a cheap facsimile of the 15th **American** edition—a copy of the British original's 18th edition. It has been on sale for a year or so in America (at $5.95—compare the British price!) under advertising blurb which figures very prominently a certain Dr. John Crocco, who must regret lending his name to this rather shabby book-selling manoeuvre. The American version has been advertised at least once in the "Scientific American", which does not increase one's respect for that journal.

In fact this facsimile is in no way "classic"—only a British edition could be so considered; and in any case the British 15th edition (from which Dr. Crocco's chick has been hatched) was in no way distinguished. Both were published in 1901, i.e. 43 years after Henry Gray's book first appeared in 1858; and while considerablee expansion and improvement had then occurred, the successive 78 years in the 20th century have produced even greater changes. The level of illustration in the 1901 book does not compare with later editions, and so it would be almost dishonest to recommend this undistinguished facsimile to artists. No "Physician" would wish to have a book which is 78 years out-of-date; and to recommend it to students is rankly irresponsible. Only the "medically inquisitive" are left, and they should be informed that the secondhand shops are glutted with much more recent and therefore more "medically" valuable editions. Besides, this is a book of anatomy, not of medicine.

The collector, appealed to specifically on the dust-jacket, would be better advised to look for (a) **The British Gray's Anatomy**, (b) an early edition, preferably the 1st, or (c) a very recent edition. Only (a) or (b) can be regarded as "classic".

This facsimile is a most misleading publication. Medical graduates would find it of little interest and even less usefulness; students should be strongly warned against it, though doubtless few would be so naive as to even consider buying it. Others, "medically inquisitive", must make their own judgement, but the above facts may persuade them that this so-called "Classic Collector's Edition" is not only a mere facsimile but also a very unrepresentative shadow of the British Gray's Anatomy.

Yours faithfully,
ROGER WARWICK.

The War Memorial Arch

Sir,

On page 490 of the Christmas number of the *Gazette* is a photograph of the War Memorial Arch.

This was taken down when the new buildings across Great Maze Pond were being built and now lies—or did until recently—a pile of stone at the back of St. Olave's Hospital.

I believe the Governors of the Hospital were appointed trustees of this Arch so that it might be maintained in perpetuity.

It is surely time that it were re-erected within the grounds of the Hospital or School, and before weathering crumbles the stone and renders the inscriptions illegible.

I am,

Yours truly,
W. N. MANN,

Keats' House,
Guy's Hospital,
London, SE1 9RT.

The War Memorial Arch

Sir,

When recently I was in Guy's I saw the plaque in the Colonnade stating that the Park at the end of the colonnade was a Memorial to the 90 Guy's Men and Women lost in the 1939-45 war. I felt outraged, bceause the Park had been there since I became a student in 1926 and it is in fact a Burial Ground for some of those who died in the Plague of London (1665). Surely we could do better for those who gave their lives in the cause of freedom. I asked if there was a Roll of Honour as I could only remember about 20 names, but I was told by several old colleagues that there

was not. I then asked what had happened to the majestic gate which used to be at the entrance to the Park from Old Maze Pond (now the roadway enclosed in our grounds) and bore the names of those who gave their lives in the 1914–18 war. Apparently it was too narrow to permit the fire engines to enter the Park and has been taken down and stored "somewhere in the country". The Chaplain came to my rescue and told me there was a book in the Crypt adjacent to Thomas Guy's Tomb and sure enough there was an elegant leather book of Remembrance covering both World Wars, but I wonder how many people go down to the Crypt and see it. We were all in that war together whether as Civilians, Home Guard, Landgirls or in one of the Services and we endured according to our "lot", because we had a faith in the survival of the British Empire and the preservation of freedom for the threatened nations of Europe. We know to what extent we won and lost and the pattern of the post war years have changed the outlook on life. We can no longer sing "Rule Britannia" (except at the last night of the Proms) but we can still sing "Land of Hope and Glory". And it was for this that Guy's Men and Women fought and some died. We may feel it is time to forget all that and build this "Brave" New World and so we should and do justice to the needs of humanity. But remember that if there had been no sacrifice in both World Wars there would be no freedom and we owe it to those who fell to honour their memory in perpetuity. The National Health Service has made life more impersonal, but it was born of that change in social conditions brought about by circumstances in the first half of this century and it should be mindful of those who perished to make it possible for the Beveridge Plane to lead to the dream of a National Health Service and give it LIFE. Let us not forget.

I wonder if we could erect the old Memorial Arch for the first war across the path leading jointly towards the Nurses Home and the Medical School and on it or nearby another small plaque bearing the names of those who fell in the 1939–45 war.

P.S. Since writing to you I have been taken for the first time to see the East Wing and I was very pleased to find there was a handsome Memorial Screen to both wars in one of the Common Rooms. This is excellent, but it is viewed by a limited public and I still feel the sentiments of my letter hold.

I am, Sir,

Yours, etc.

DAVID ERSKINE,
(Guy's 1926–47)

Sutton Rise,
Ogmore-by-Sea,
Bridgend, Glam., CF32 0PE.

Guy's R.F.C.—An appeal for team photographs

Sir,

In the near future it is intended to have the surviving group photographs of the 1st Rugby XV bound and kept at H.O.P. for people to look at. Copies of some of the more famous teams have been made for display on the walls.

At present, the earliest photo available is the "20" of 1876/77—the winners of the 3rd U.H. Cup Tie. If any reader knows of the existence of an earlier photograph—particularly the team of 1874/75 which won the first U.H. Cup Tie, it would be kind if he would let either one of us know so that we may seek to obtain it or have it copied.

There are numerous other gaps in the existing collection and if any reader can present us with a photograph of any of the following 1st XVs it would be greatly appreciated:

1877/78, 1880/81, 1882/83, 1884/85,
1886/87, 1889/90, 1892/93, 1896/97,
1903/04, 1923/24, 1924/25, 1930/31,
1933/34, 1936/37, 1938/39, 1944/45,
1948/49, 1950/51, 1952/53, 1953/54,
1955/56, 1956/57, 1962/63, 1968/69 onwards.

To avoid a flood of photographs, donors are asked to send a letter of intent first and not the actual photograph or photographs.

Yours faithfully,

TOM LEWIS,
Department of Obstetrics and Gynaecology.

TERRY GIBSON,
Department of Rheumatology.

Medical School Security

Sir,

I have had my attention sharply focused on security in the Medical School by the theft of my wallet, cheque book, cheque card and driving licence on one of the quiet days between Christmas and the New Year.

I am told that it is my fault and that I cannot leave my office unlocked for 10 minutes while I am working in the adjacent room. That I must expect someone to enter my office stealthily and

remove my personal possessions if I leave them while I go to the "loo" on the floor below. Some how I cannot accept this. My initial reaction was shock, followed by frustration and anger. I know that my experience is by no means unique and that has prompted me to write on the general problem of security in the medical school and hospital. One suggestion I could make is that all students and employees of Medical School and Hospital should wear personal identity badges (with photograph). In the past I would have been against this idea but times have changed. The hospital and medical school are much expanded in area and staff so that it is impossible to know everyone by sight as one could previously. The incidence of theft is now extraordinarily high. I understand from the police that the use of personal identity badges has worked well at University College Hospital.

I believe that the security of the medical school is included with that of the hospital. It would seem that, as in a number of other things, the school is getting rather a small share since I cannot remember seeing any evidence of a daytime security check in the medical school. Perhaps the medical school should employ specifically a daytime commissionaire. Admittedly there would be little point in him only guarding the front door of the school. It would be necessary for him to generally patrol the school. The presence of so many different exits and entrances makes it very easy for a thief to enter undetected and to get away afterwards by a different route. The number of entrances could be reduced to two.

Would it be unacceptable to the students and staff if a series of traps were to be laid to attempt to catch the guilty person or persons?

I would welcome any ideas on this subject because I feel that one should be able to get on with one's work without having constantly to be thinking about leaving everything locked up all the time.

Yours faithfully,

D. R. TURNER,
Department of Pathology,
Guy's Hospital Medical School,
London Bridge, SE1 9RT.

Review reviewed reviewed!

Sir,

In a letter (Christmas edition) Dr. Roberts suggests that I had not read her book **Doctor and Patient in the Teaching Hospital** before writing the review which appeared in the Gazette earlier this year. She claims this on the grounds that two research approaches to the doctor-patient relationship, which I argued she had not used, were in fact encompassed within the book. If Dr. Roberts is right about her research methodologies then I think it perhaps understandable that I failed to recognise them.

In my review I suggested she had not used the "survey" technique; but Dr. Roberts now points out that I ignored the fact that she "interviewed" all her respondents. Yet these were strange interviews for a survey. Her sample of respondents was not in any way scientific ("serendipidity", it is called in the book). The actual "interviews" were not structured nor was the methodological rigour of unstructured interviews observed: in fact they seemed more like casual conversations with chance comments ("perceptions") from passing strangers being equally admissable as valid data (p.13). There was no discussion of reliability or validity of interview data; the few rating scales described are used in a fairly arbitrary way assignment apparently being based on Dr. Robert's first impressions of the respondent. It seems to me therefore that in the limited analysis of numerical data (p.30-36) very little credence can be placed on supposed links between, for example, a doctor's "dominance" and his "interactive style". If Dr. Roberts does use the survey techniques in her book therefore—and she now claims she does—I think it must be judged completely inadequate.

Dr. Roberts also claims in her letter that the bulk of her book discusses the belief systems of doctors and patients despite my statement to the contrary in the review. She may again be right, but if so shows no awareness of the significant differences, both empirical and conceptual, between a belief or attitude and a belief system. Moreover her analysis of belief systems seems to have been forgotten when she concludes that the solution to doctor-patient conflict is "mutual awareness and mutual education". This wholly ignores the very real constraints, both cognitive and structural, preventing the doctor from truly "knowing" the patient's perception of ill-health or the patient "knowing" the doctor's knowledge and skill.

If, as Dr. Roberts suggests, in my review I ignored two of her methodological approaches it seems to me it was not because I had failed to read her book but rather because they were either

too perfunctory or too obscure.

Yours faithfully,

DAVID ARMSTRONG,

Unit of Sociology as applied to Medicine.

Guy's Hospital, SE1 9RT.

Accountability in the N.H.S.

Sir,

Mr. Ellis in his article Too Little Surgery, Too Much Science has, on occasions, left the boundaries of his title and commented on the general running of the Health Service, during which he has tended to produce a few generalisations which bear some inaccuracies. He states, for instance, that "professional opinion has too little weight", when referring to hospital management. One wonders how big "little" is when considering the present administrative set-up. The district management team, D.M.T., is composed of the following: District Administrator, District Treasurer, District Nursing Officer, District Community Physician, A Consultant representative and a General Practitioner representative. This majority representation of the professionals has no parallel in any other sphere; for example teachers have minimal representation on the Board of Managers of a School. In comparison to other professions, the medical professional has a great deal of weight, if not excessive.

The little anecdote about the Community Health Council was most disturbing; perhaps if the House Surgeon referred to had the common sense to explain to the patient his action, no complaint would have arisen. The Community Health Council has **no** statutory authority, it is the sole body, except for the courts through which the patient can articulate his feeling about the Health Service. As such it represents the patient with only the power of persuasion and advice, and carries far too little weight compared with the professional big battalions.

I do not believe that anyone has conclusively shown that medical care rather than improved socio-economic conditions has increased the life span of the general population. As for the "quality of life". I think it true to say that if the level of health service was the same as twenty years ago, the quality of life of groups such as the elderly, the handicapped and the chronically sick would be far worse than it is today.

Mr. Ellis concludes on the idea of the person in charge of Guys. Just as schools are too important to be left to the control of teachers, so hospitals such as Guys and the Health Service in general are too important (and complicated) to be left in the control of doctors. Similarly I think the idea that administrators should administrate and doctors practice medicine is just as nonsensical. The Health Service is there to serve the patient and without accountability, no system of running the Health Service will be acceptable, whether it is done by Government or by professional élitism. Unless those controlling the Health Service are accountable to the public, and realise they can be relieved of their responsibility when they make a mistake, we will continue to have incompetent decisions taken by those who have to answer to themselves alone.

Yours faithfully,

NIGEL KONZON,

Medical Student.

c/o Boland House.

Do M.C.Q.'s provide the answers?

Sir,

Over recent years there has been a definite trend towards the increased use of M.C.Q. examination papers, and the argument for this method of examination is that it is a scientific assessment of how much a student knows. One really cannot argue against this fact but I think there is much to be said against the extensive use of M.C.Q.'s, particularly for those at the end of their medical school careers, when good examination results are so vital.

The problem with using this method of assessing a student is that it does not allow one to express opinions, ideas and detailed information which a student may have. Essay questions however, because they have a much wider scope, do allow for this and are therefore far more beneficial, especially to the student taking his finals. He will hopefully, be in a position to give detailed and intelligent answers, and also provide examples (possibly gained from clinical experience), where there is an exception to the rule. This is not possible with an M.C.Q. paper as it is too rigid.

It was distressing to hear that in certain firms the quality of the sign up was dependent on the results of the M.C.Q. rather than clinical performance and attitudes of the student on the wards. After all, a good doctor, in whatever field must have a certain manner with patients and must be able to convey to the patient a sense of trust. I am by no means underrating the need for an examination system, indeed our whole education structure is based on the examination system. A proficient

doctor needs far more than an acceptable bedside manner and warm hands, but I put forward the suggestion that the M.C.Q. system does not do justice even to the best students. Furthermore, a doctor aiming for the M.R.C.P. and other higher échelons of the medical profession cannot be expected to reflect his true knowledge and experience in a multi choice examination paper.

Certainly medical schools and examining bodies should take another look at examination methods and endeavour to include more essay orientated papers, so that the student in whatever field of medicine, can do himself and his school justice at the end of the course.

Yours faithfully,

C. LAKE,

60 Foyle Road,
Blackheath, London, S.E.3.

Sir,

On 11th March, 1972 you carried an Obituary Notice on my father, Frank Cook, F.R.C.S., F.R.C.O.G. Some of your older readers may wish to know that his widow (who will have been known to them as "Dick") died peacefully in York on 1st December, for they were considerable Guy's personalities in their day and were held in affection by their generation. My mother would have been 90 on Christmas Eve.

Yours faithfully,

F. P. COOK,

5 Malton Way,
Clifton Without,
York, YO3 6SG.

Sport

This month your revered sports editor, Jon Earnshaw, has gone to teach the Americans soccer, and a few other things beside. Unable to leave the mountains of West Virginia and its country roads and return to Guy's to edit, I have been volunteered to fill the gap.

The past month has been relatively quiet as regards hospital sport with many students having long vacations. Guy's sportsmen have had to resort to spending the long evenings in the bar or local, talking of famous victories, defeats and characters of the past. However there are some reports of late November and early December.

Recently I have become aware that some people (and not just women) do NOT like sport. I was stunned by this realisation, never before even contemplating such a notion. Doesn't everyone start from the sports pages and then read backwards? Doesn't every man frantically search for a radio or television at 4.45 on a Saturday? It distresses me that some do not know the Joy of Sport. Perhaps someone would write to the *Gazette* explaining how anyone can live a Sportless life.

To explain the appeal of sport to the uninitiated is difficult especially without lapsing into the sportswriters' favourite phrases — glorious clichés! Perhaps it can be partly explained by saying that sportsfields are the only places where one can express oneself and get away with it. Team games especially are great social events—you are never short of anyone to have a drink or a bath with. Whilst playing sport you can experience rare emotion of every kind (well, almost) and subject your character to rigorous scrutiny (nasty!). I hope this has been a help to all those who do not understand the mystery of sport.

Good luck to all Guy's men and women and teams in the coming month. May your pass be good, your kick strong, your racquet taut and your right arm never still.

GARY CALVER.

HOCKEY 1st XI

v. Christ College, Cambridge—Drew 2—2 (Plowman and Wyeth) 11th November

On a wet dark day both teams started slowly. Guy's scored first through Nick Plowman then lack of effort set in with only Chris Barris and Simon Wyeth playing well. Garth and Holmes were quite intent in trying another Plowman type window demolishing act at free hits. Thus short corners were needlessly given away and John Pascoe was called upon to perform. Eventually Christ College equalised and even after strong words at half-time we were still just as bad. Pete Holmes typified the whole performance by gaining the T.T. award with a football-like attempt at striking the ball. At this point Christ College scored after playing some good constructive hockey.

This woke the blues up. Simon Wyeth equalised from a fine cross from Chris Barris. In the last few minutes Guy's were denied a victory by an unsighted umpire. Not a notable performance, no beer on Friday night must be the answer.

Team: Pascoe, Saward, Holmes, Gulamali, Hett, Sanders, Barris, Jones, Plowman, Wyeth, Karim.

v. Peak Freans (League)—Won 3—0
18th November

Guy's started like racehorses in this match which makes a great change. Wave after wave of attacks beat down on the biscuit boys end and only a stream of ridiculous decisions from the opposition umpire prevented a goal. Good attacks were made down the left wing with Pete Sanders and Niaz Karim causing the trouble. A goal had to come, Chris Barris produced a superb cross and after the keeper had saved the first attempt from Jones, Wyeth forced the ball over. Unfortunately our captain marred a great personal performance by showing a soccer-like characteristic called dissent at the custard cream umpire. In the second half Guy's were still all over them with Shiraj starring at right half combining well with Chris and Duncan. Plowman thundered in a further two goals which finished the opposition. John Pascoe had nothing to do except to support the goal post. A great game, the first time we have produced a sustained team performance this season. Thanks to Clive for providing some sanity with a whistle.

Team: Pascoe, Saward, Holmes, Gulamali, Hett, Barris, Jones, Plowman, Wyeth, Karim.

v. S.T.C. (League)—Won 6—1
25th November

Again Guy's started like dynamite and soon moved into the lead with a goal from Rick Plowman. He soon repeated the feat after a great cross from Niaz Karim. We then decided, as it was cold, to hibernate. At half-time, still only two goals up, we heard we were second in the league on goal difference. This spurred us on to greater efforts and Duncan Jones soon scored from the right with a strong shot. Guy's now tore S.T.C. apart and Rick Plowman with the scent of scotch in his nostrils added the fourth. Hett still, quite wrongly, believes he scored the fifth (the team will humour him). We would have had 10 if Simon Wyeth has listened to his caddy and taken a long iron. With such great play from the forwards the defence just had to rum it; Garth in attempting to play left wing kept falling over and Pascoe's kick (note singular) left much to be desired. The victory puts Guy's well clear at the top of the league. Well done boys!

Team. Pascoe, Saward, Holmes, Gulamali, Hett, Sanders, Barris, Jones, Plowman, Wyeth, Karim.

v. Bowaters (League)—Won 1—0
2nd December

Guy's started the game with only 10 men as Shiraj was **again** late, and were soon under pressure from a sharp Bowaters side. The defence held solid and soon the Bowaters goal was threatened, but with a weakened side Guy's could not get the breakthrough. Just before half-time Bowaters were awarded a penalty and John Pascoe kept us in the game with a great save. This was just the inspiration we needed and the second half was all Guy's with Seb Johnston and Rick Plowman linking well up front. With about 10 minutes to go Jones got behind the defence and crossed back for Plowman to score. The game ended with Guy's well in control. This victory keeps Guy's at the top of the league and with only three games left to play things look good for promotion.

Team: Pascoe, Saward, Holmes, Gulamali, Hett, Singe, Barris, Jones, Plowman, Johnston, Karim.

DUNCAN JONES.

Kent Cup 1st Round v. Reeds
(4—3 after extra time)

The draw produced a match between the joint leaders of the league, and was to be the first ever meeting of these two giants of the division. From the start the sides were locked in fierce combat. The possessional play was even but our forwards used the ball better and it was only their keeper who saved at least a dozen well struck shots, that the score stayed at zero. Reeds had some very good attacking moves but these were thwarted by our renowned full back combination of Saward and Holmes. The umpiring was provided by two County umpires who gave good advantage decisions. It was from one of these that we scored just before half time. Jones' shot was saved and whilst obstruction occurred the ball rolled out to Chris Barris, the winger. He had not hit a shot in anger before and the game stopped so that everyone could witness the occasion. He picked his spot carefully, several times, and then hit it into the opposite corner—a great goal!

In the second half Guy's let the game slip a bit and after continued pressure Reed's hit outside the circle was obstructed before it was taken. A penalty

short corner was given and was neatly put in the net. The draw caused a further ten minutes each way or five penalty flicks each. The former was chosen as Guy's are a very fit, athletic side and are easily able to manage this. The first ten minutes produced only excitement. The second however produced good attacks and goals from Karim and Plowman. As Guy's prepared to receive the trophy, Reeds slipped one back and a concerned Guy's team tightened up and the match ended in a good result which reflected upon the solid play of Forber and Straker and could only leave hundreds of paper mill workers saddened.

Team: Oastler, Saward, Holmes, Gulamali, Forber, Sanders, Barris, Jones, Plowman, Straker, Karim.

R. PLOWMAN.

MOUNTAINEERING CLUB

Yet another expedition to North Wales was made by Guy's M.C. last weekend.

Fifteen of us bravely left the zero temperature of London on Friday evening and sped across the U.K. to the sub-zero temperatures of Snowdonia. The minibus only ran out of petrol once in seven hours. Later we were all under the friendly (if damp) eaves of the U.L.U. hut, which is under the shadow of Tryfan and miles from anywhere.

We woke the following morning to find that it was neither snowing, nor raining, so after much discussion while eating cornflakes, bullying during the egg, and subtle persuasion over the toast, the Guy's contingent formulated its plans for the day.

Six climbers set off for the crags and pinnacles of Tryfan while the rest of us split into walking parties. Judith and Nick climbed the north ridge of Tryfan, Jean and Nick M. traversed Tryfan and onto Bristly Ridge, and five of us started to ascend the slopes of Pen-yr-Olewen at the end of Carneddau ridge.

We had soon crossed the snowline, and by the time we had reached the summit, the view had been obliterated and we were enveloped in a blizzard while we ate lunch. For most of the ridge walk we could see very little, except on occasions when the mist was blown away, and we were able to look down into the valleys on either side, and out to Anglesey on our left.

After a day of peak-bashing we were quite glad to walk down the last shoulder of the ridge to the hut. Everyone else had returned when we staggered in, except for André and Andy, who came in later, after a busy day spent in rescuing abandoned Welsh maidens from the hostile bogs of Tryfan.

After supper we drove to the local hostelry, to sit in comfort while being told of all the famous mountaineers, and famous mountaineer's rucksacks that had been spotted on previous trips.

On Sunday we went to Snowdon and while André and Mike climbed, everyone else tried various permutations of walking the whole or parts of the horseshoe.

It was a perfect day for Snowdon. There was plenty of snow and we were glad of ice-axes, but the sun was shining and there was a superb view in every direction.

While the two Nicks walked the whole horseshoe from one end, and Adrian and Hamish from the other; Jean and Judith walked to the summit via Lliwedd and we climbed Crib Goch and scrambled along the ridge to the top of Snowdon, before coming down the Pyg track.

Everyone had reassembled in the café at the bottom by 4.00 p.m., and one and a half hours later, having returned to the hut and loaded the gear, we were on our way back to Guy's, after a successful and very enjoyable weekend.

Our thanks must go to Pete Davidson without whom we would have had to walk 600 miles.

MARY ILLINGWORTH.

GOLF

THE GUY'S OPEN '78

There has recently been correspondence in these pages regarding the general ill-health of the Golf Society, in particular the alleged hilarity of the occasion earlier this year when an incomplete and tardy team was fielded against the might of the hospital's consultants. This was an unfortunate incident, but by no means typical —indeed there is every sign of improving interest and good health in the Society. At our recent A.G.M., a new committee was elected and I would like to thank the outgoing members as well as wish the new members good luck in their positions . . . (and I will still get in the team, won't I Nick?).

If undergraduate golfers can be criticised for their apparent apathy, then no such thing can be said of the hospital staff. This year 20 of the best at Guy's entered the Guy's Open, a knockout competition begun ten years ago by Kenneth Maclean, the prize being a magnificent silver trophy—and a handicap of two strokes the following year! Last November the final was contested by Dr. Maclean and Tim Coltart, and turned

out to be as vicious and nail-biting as any Ryder Cup match.

The interested parties met on the freezing links of Tandridge G.C. soon after sunrise one Sunday morning, preparing for their epic duel. Opening shots were fired in the changing rooms, when Coltart began reminiscing about the time he entered the British Open at Wentworth. Maclean however feigned indifference, but felt the need to go and sink a triple scotch. With his courage thus bolstered, he then loosed his secret weapons; firstly he introduced his caddy, recruited from his firm in a slack moment one afternoon in outpatients; and secondly he gently swung a club and remarked at the tensile advantages of titanium shafts. Coltart was clearly shaken at seeing these famous clubs but was man enough to concede that if anyone was able to spend £500 on a set of clubs, then maybe he was entitled to a small advantage. The caddy then put away a few dark and warming rums as insulation, and the match began.

On the 1st, Maclean got down in two from 40 feet for a steady four, to go one up. Coltart, still suffering from the shock of seeing Maclean's titanium shafts, promptly drove in the wrong direction at the 2nd and conceded the hole. At the 3rd, both men lost their balls, but Coltart scored a point by asking whether Maclean was playing with titanium balls as well, and if so, didn't this look like being a rather expensive round for him? Maclean began to mutter to himself, but did not seem to be too shaken since he won the next three holes to be 5 up at the turn.

At the 10th tee, taking out his 3 wood to drive, Coltart found it to be in two pieces, and so was forced to use his driver. Miraculously, he suddenly looked to be worth his old handicap of 1 again, and promptly pulled back the next four holes to be only one down. From then on it was nailbiting stuff and Maclean was clearly getting worried. Was he going to blow it, at the eleventh hour?

By halving the 17th Coltart needed to win the last to force the play off. He drove first, a fine shot that extracted a groan from Maclean. But thanks to some timely advice from his caddy, Maclean slowed his back swing and hit a perfect snap hook (a shot which is ideal for the 18th at Tandridge, although not generally advisable)! But what an anticlimax—Coltart sliced his second shot down the hill and irretrievably into trouble, so forfeiting his chance of winning the hole. I have rarely seen a man look so absolutely delighted as Maclean did as he watched Coltart's ball sail 200 yards away into the gorse bushes.

Neeedless to say, it was drinks all round, and the victorious caddy was very generously rewarded (hic)! It was very fitting that the founder of the Open should be victorious in this his last year at Guy's and I am sure that Coltart was not too disappointed at coming second.

The opening rounds of next year's Guy's Open will be held sometime in Spring 1979, but entries must be in well before this time. A notice will appear in the Gazette at the time entries are required. All doctors at Guy's who have been qualified for more than a year are eligible to enter the Open, and it is hoped that next year's entrants will be more numerous than ever. And if any student golfers feel like doing their job prospects a little bit of no harm may I suggest you offer to caddy for your favourite consultant? BOB HEARD.

GUY'S SQUASH TOUR TO CAMBRIDGE

On the weekend of the 11th of November Guy's Squash Club went on their annual pilgrimage to Cambridge. This year we were especially hopeful of good results owing to the hard training that most of the Club's members had been partaking in all term. Alas, this was not to be so despite the inclusion of the four superlatively fit individuals of the team.

The success of the occasion, however, cannot be judged by squash performance alone, which is just as well, otherwise squash tours at Guy's would have had to go out with the Ark.

The tour began on the Friday night when we played St. John's and lost narrowly 2—3. Good wins were achieved by Victor Tun and Paul Sanders both of whom had strong opposition. The story was the same the following afternoon when we were just beaten by Magdalen College 3—2. Jonathan Pringle and James Murch were the only victors on this occasion. Better luck was on its way and on the Sunday, determined not to make a hat-trick of losses, we easily overcame a weak Churchill side by 4 games to 1; Steve Des Clayes once again being the unlucky loser.

Our thanks go to Victor Tun for organising the tour and also Russel Picot of St. John's College for once again acting as landlord, host and entertainer.

The team consisted of: Victor Tun, Paul Sanders, Steve Des Clayes, Jonathan Pringle and James Murch.

JAMES MURCH.

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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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Passim

The death of Charles McHugh, Britain's fifth heart transplant patient, has resulted in the predictable cries for the abolition, or at least pruning, of these "esoteric surgical practices".

It was the French writer Andre Gide who said that the great artist must swim against the current of his time, although it is more accurate to say that unorthodox and original views will, by their very nature, arouse hostility and resentment in those of a more complacent disposition.

Much the same sort of views were directed at pioneer transplant work in renal surgery and yet the bizarre has become the commonplace; the current of the times has changed.

Some would profer the argument that cardiac surgery of this nature is financially prohibitive, current estimates being £20,000 per operation. It is, however, important to consider: weekly sickness benefit over the years that the patient would claim, the loss of earning power of spouses who have to become nurses over-night and, not least, the continuing burden on the N.H.S. to support the patient. Considerations such as these go a long way to taking the sting out of the argument that such operations are beyond the economic pale.

It is important that British surgeons are allowed the opportunity to gain experience and, by practising more sophisticated techniques, to remove the spectre from what is, admittedly, a fledgling enterprise.

Part of the reason why Shumway in America is allowed to perform 25 such operations per annum is not just that there is more money but that there is more success and this because there is more practice.

The saying, nothing ventured nothing gained, is misleading in that we sometimes benefit by sheer providence, but it does express the core truth that the history of progress is the biography of persistent struggle.

Indeed, it has to be since the acquisition and growth of knowledge pre-supposes our ignorance and ineptitude, and we persist because we are, eventually, successful.

If we are faint-hearted in this resolve then people even more faint-hearted than us will suffer.

Medical Directory — Zeitgeist Unfavourable ?

There seems neither the will nor the finances to support the preparation of a new edition of the obsolete Guy's Medical Directory at present. The Medical School Office points out the large stock of unsold 1969 editions, perhaps indicating an over-enthusiastic print order rather than sluggish demand. Some people will be watching the sales of the new Dental Directory with interest as a pointer to whether a new medical edition can be justified.

The *Gazette* believes that a new Medical Directory is thoroughly justified, but it could hardly be expected to believe otherwise. This journal, after all, survives because Guy's graduates maintain a loyalty to and interest in their Hospital. Both it and the moribund directory foster the idea of a "Guy's community", which in today's environment carries overtones of élitism and a back-slapping camaraderie that has rather gone out of fashion. In practical terms a new directory may be supported by the older members of the fraternity—several of whom have been heard to utter that they would pay £10 for a new copy—but is it the sort of publication that a graduate of the sixties and seventies would ever use? We look to the sales of the new Dental Directory for an answer.

The work involved in preparing new address and locality lists is considerable, but not beyond the capacity of a part-time secretary, or a couple of students working a holiday job. In today's terms the money involved is not large. Guy's will lose intangible but possibly vital benefits if it loses its "community". The foundations of such a community are men with memories long enough or records up to date enough to keep the periphery informed. With our Jimmy Goodliffes and Arthur Wallises retired it is to records that we must turn. Sadly, we find them drifting into obsolescence.

Guy's Hospital Dental Directory

A new edition of the Dental Directory is now available to our dental subscribers, containing up-to-date alphabetical and locality lists of Guy's practitioners.

Available from the Sub-Dean of Dental Studies, Medical School, Guy's Hospital, London, SE1 9RT.
Cost £1.25 (inc. postage within U.K.)
Cheques to be made payable to Guy's Hospital Medical School.

PISCIM

With unemployment over a million and inflation well into two figures, the passing of the Guy's Dry Fly Fishing Club (see *Correspondence*) may not seem a very significant event. Nevertheless the loss of friends, old or new, is profit to no one; even when the end of the affair was quite obvious to so many people from its very initiation. The Club's history was dogged by the long closed season, a lack of all round fishing ability and, not least, the increasing constipation of the medical student's calendar. This remembered, it has to be admitted that they received little encouragement from others, not least this hospital, where they were considered to be eccentric outsiders. Pioneers are rarer today than ever before; they need support from all of us, indeed even from those that oppose them. It is to be hoped that the events of the last week may have taught us all a lesson, and that there will be no shilly-shallying on the next occasion that a Guy's club is under similar threat.

The Friends of Guy's Hospital

The Christmas Stall, held in the Colonnade and run by the *Friends* raised the sum of £670 for their funds. I should like to take this opportunity to thank all those many helpers who, despite the inclement weather, made this venture such a success. At the same time, may I say how much we appreciate the generosity of those who sent gifts for sale and those who bought tickets.

* * *

It is not planned to hold a Summer Fête this year. The next one is intended to take place in 1980.

There will, however, be a GRAND RAFFLE for which tickets are now on sale. There are many magnificent prizes to be won, including a holiday for two in a luxury hotel in Devonshire and a portable television set. The draw will take place at the Annual General Meeting of the Friends on WEDNESDAY, 2nd MAY, in the TOWER LECTURE THEATRE.

The *Friends* is a very active organisation which raises large sums of money which are used to provide amenities for the patients and staff. It also makes a substantial contribution towards the Research Fund of the Hospital.

It is entirely a voluntary organisation and anyone who wishes to help can contact either Mrs. Mylchreest, Secretary of the Friends, or Mrs. M. Campbell, Secretary of the Services Branch of the Friends. Those who are particularly interested will be very welcome at the Annual General Meeting in May.

Margaret Helliwell,
The Chairman,
Services Branch of the Friends of Guy's Hospital.

News in Brief

Quodlibet Society

The next meeting will be on Monday, 5th March when Dr. Martin Cole, Director of the Institute of Sex Education asks "Sex Therapy—Sin or Salvation?"

About this month's cover

The Immortal Churn—mascot of the Guy's Hospital Rugby Football Club—needs no explanation. The *Gazette* looks forward to the day when it can once again be paraded in triumph! *(see Correspondence, page 92).*

Improvements to St. Christopher's

The Herbert E. Dunhill Trust, which has supported the School so generously with grants for a wide variety of purposes, has given £15,000 for improvements to St. Christopher's House. These comprise making three extra study-bedrooms out of the disused dining room and converting the old fashioned kitchen into one that is more appropriate for the catering needs of the residents, and into a small dining area and a laundrette.

Newland-Pedley Travelling Scholarship

This Scholarship will be awarded to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to undertake a year's postgraduate dental study at one or more Dental Schools or Colleges abroad approved by the Dental Council. The value of the Scholarship will be up to £1,500 and the actual amount of the award will depend upon whether the holder of the Scholarship proposed to spend a year at an institute in Europe or Scandinavia or whether the year will be spent in Canada or the United States. The holder of the Scholarship may be required to undertake teaching duties in this School for the academic year following that in which the Scholarship is held.

Dental Travelling Scholarship

This Scholarship has a value of £250 and is awarded every year to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to study at one or more Dental Schools abroad which are approved by the Dental Council.

In order that applications for the Travelling Scholarships may be considered by the Dental Council in sufficient time to enable the successful candidates to make arrangements for travel, etc., it is necessary for all applications for Travelling Scholarships for 1979 to be received by the Dean of Dental Studies by Friday, 4th May, 1979.

The Dean of Dental Studies will be pleased to discuss the matter with anyone who is interested.

Guy's Hospital East Anglian Society

The Guy's Hospital East Anglian Society's Dinner for 1979 will be held on Saturday, 12th May, at Pembroke College, Cambridge, at 7.30 for 8 p.m.

The President will be Dr. A. A. Craigen and the Guest of Honour will be Dr. A. M. Hutton.

If any Guy's East Anglian has not received notice of this Dinner, but would like to come, would he please write to

Dr. C. Bishop,
Department of Anaesthesia,
The Ipswich Hospital,
Anglesea Road Wing,
Ipswich, IP1 3PY.

Moving House

In a few weeks' time the *Gazette* will be vacating its gloomy Dickensian offices at 16 St. Thomas Street and moving across the road to spacious premises at number 11, provided by the Special Trustees. The move has been made necessary by the redevelopment of the west wing and St. Thomas Street south side. The *Gazette* hopes to advertise its presence by some sort of door sign, though as these are highly prized by wandering hooligans from adjacent hospitals our subscribers are urged to make note of our impending move.

Music Club Concert

The next Guy's Hospital Music Club Concert will be on Friday, March 9th, at 7.30 p.m. in the Greenwood Theatre. The programme will include two Dvorak Slavonic Dances, a Negro Spiritual, Mozart's Vesperae Solennet, Vivaldi's Gloria, and will be conducted by Peter Soothill and David Melville. Tickets will be 50p, at the door, in the Colonnade at lunchtime, or from members of the choir or orchestra.

Monthly Meetings of General Practitioners, Community Doctors and Consultants of Guy's Health District.

These meetings are to be held in the Robens Suite, Guy's Tower (29th Floor), on the third Wednesday of each month for the first six months of 1979.

They will start at 12 noon and continue until 2.00 p.m. Lunch will be provided at a cost of 50p.

A subject has been chosen for each meeting by Mr. Schurr, the Sub-Dean of Postgraduate Studies, in consultation with Dr. Rosser, representing the District Medical Committee.

The introductory speakers have agreed to speak for 10 - 15 minutes and start the discussion :

Wednesday, 21st March—"Haematology Problems". Introductory speaker: Dr. K. G. A. Clark.

Wednesday, 18th April—"A District Dietetic Service". Introductory speaker: Mrs. S. E. Butson.

Wednesday, 16th May—"Paediatric Dermatology". Introductory speaker: Dr. R. S. Wells.

Wednesday, 20th June—"Poisons". Introductory speaker: Dr. R. Goulding.

Dates from the Medical Diary

March

Fri. 2 Entries close for the Treasurer's Medal and Prize and Baldwin Prize for Clinical Medicine.

Wed. 7 Examination for the Treasurer's Medal and Prize and Baldwin Prize begins.

Fri. 9 Entries close for the Gillespie Prize in Psychological Medicine.

Wed. 14 Examination for the Gillespie Prize in Psychological Medicine begins.

Fri. 16 Entries close for the Beaney Prize in Histopathology.

Mon. 19 Basic Medical Sciences Examinations (5th term) begin.

Wed. 21 Examination for the Beaney Prize in Histopathology begins.

Fri. 23 Entries close for the Preliminary Examination for Studies in Medical Subjects.
Entries close for the Beaney Prize in Immunology.

Fri. 23 *SPRING TERM ENDS.*

Mon. 26 Final Conjoint Examination begins.

Wed. 28 Examination for the Beaney Prize in Immunology begins.

Fri. 30 Applications for the Ian Howatt Memorial Prizes and Draper's Company Awards must be submitted to the Dean by this date.
Entries close for the Golding Bird Medal and Prize in Obstetrics and Gynaecology.
Entries close for the M.B., B.S. (Revised Regulations) in June.

Dates from the Dental Diary

March

Mon. 5 Applications for the Final L.D.S. Examination, Parts I and III (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Mon. 12 Applications for the First L.D.S. Examination (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Fri. 16 Applications for the Third B.D.S. Examination, Parts I, II, III, IV and V (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Fri. 23 Entries close for the Preliminary Examination for Studies in Medical Subjects.

Fri. 23 *SPRING TERM ENDS.*

New Sports at H.O.P.

New team sports available at Guy's Hospital Athletic Ground from 1st April, 1979: Basketball, Netball, Volleyball, Padder Tennis, Indoor Hockey, 5 a Side Soccer, Handball, Badminton and Head Tennis.

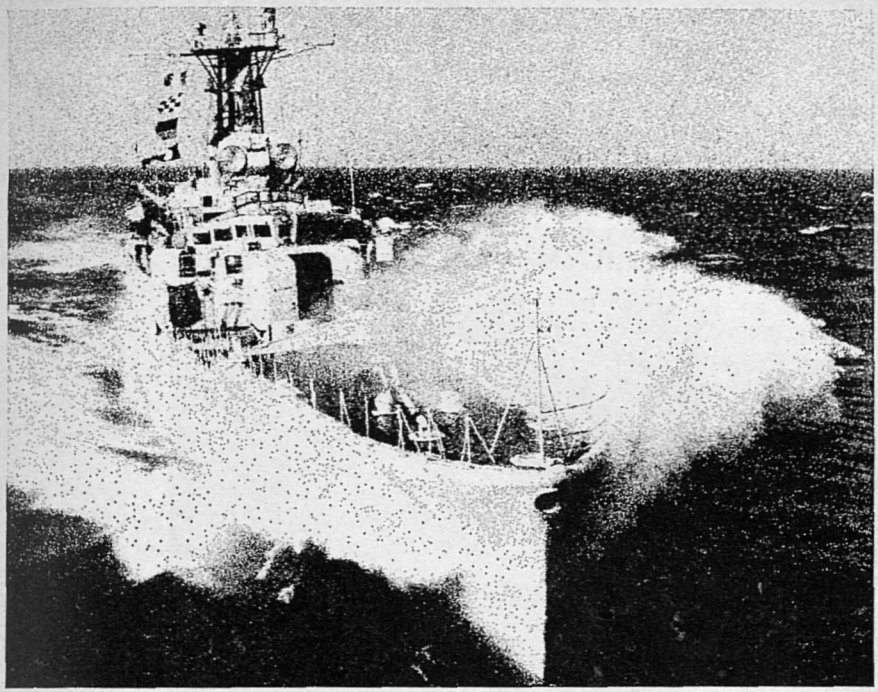
Those interested should contact Eric Dann during the day until 6 p.m. or until 8 p.m. Monday, Wednesday, Saturday. Tel.: 690 1612.

Guy's student stands in General Election

. . . so long as it comes before his Finals in June. Michael Dixon, M.A., well known to our readers as recent past Chairman of the Quodlibet Society (and chronicler of the demise of the Dry Fly Fishing Club), has been adopted as a candidate for South Devon representing the Ecology Party. The *Gazette* hopes that his ambitions will bear fruit.

Camilla Haw

With the approach of Cambridge Finals we are sorry to lose Camilla Haw this month. Camilla joined the *Gazette* in April 1978 and has made an excellent contribution to the running of the journal. We wish her the best with her Finals and career.



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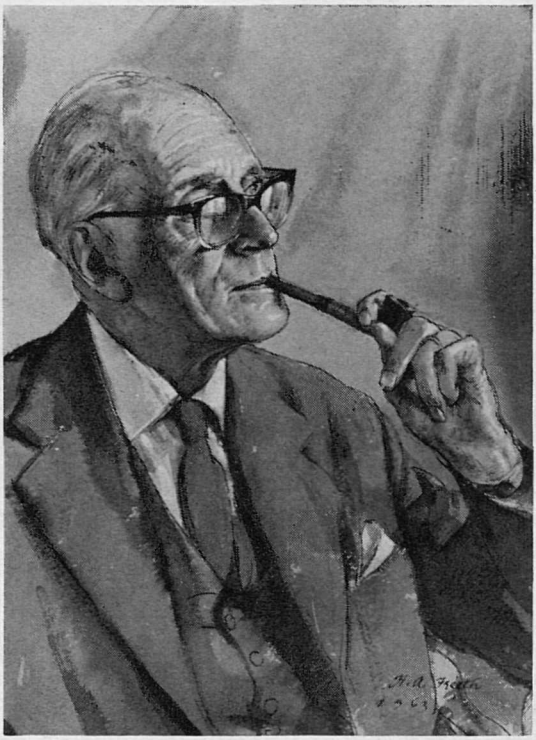
ROYAL NAVY MEDICAL CADETSHIP

Obituary

SIR CHARLES SYMONDS
K.B.E., C.B., M.A., D.M., F.R.C.P.

Charles Putnam Symonds was born on 11th April, 1890, and educated at Rugby, New College, Oxford, and Guy's Hospital, qualifying in 1915 and taking the M.R.C.P. a year later. During the first world war he served in the R.A.M.C. and was awarded the Médaille Militaire.



After demobilisation with the rank of captain he served as house physician at the National Hospital, Queen Square, and medical registrar at Guy's. He graduated M.B., B.Ch. in 1919 and proceeded D.M. the same year. In 1920 he became Radcliffe travelling fellow of Oxford University. During that year he was appointed neurologist to Guy's Hospital, shortly after Arthur Hurst had started a neurological clinic there. Symonds soon attracted the attention and respect of other neurologists by his exposition of the complex picture of encephalitis lethargica, and this was followed by an increasing flow of original work and critical reviews.

He became honorary consultant neurologist to the Royal Air Force in 1934 During the second world war he gave up his large private practice and devoted his skill and experience to service in the R.A.F.,

in which he reached the rank of air vice-marshal. He was appointed C.B. in 1944 and received a knighthood two years later. When he returned to civilian life he resumed his work in the department of nervous diseases at Guy's and at the National Hospital, Queen Square. He was honorary visiting neurologist to Johns Hopkins Hospital, Baltimore, U.S.A. In 1953 he was appointed Sims Commonwealth lecturer, and the following year was chosen to deliver the Harveian oration at the Royal College of Physicians. When he retired from the active staff of Guy's in 1955 he had been neurologist to the hospital for 35 years and had secured an enduring reputation by establishing the neurological department as it is known today.

An honorary fellow of the Royal Society of Medicine, he was an ex-president of its sections of psychiatry and neurology. At the annual meeting of the B.M.A. in 1923 he was secretary of its section of neurological and psychological medicine, and in 1939 president of the section. He contributed many papers on neurological subjects to scientific journals, and wrote the section on nervous diseases in Taylor's *Textbook of Medicine*. Late in his busy life he took up the hobby of fly-fishing.

Sir Charles Symonds will be remembered as a great clinical observer in the tradition of Hughlings Jackson and Gowers, and particularly for his contributions to the study of head injuries, epilepsy, the psychiatric aspect of neurology, and the neurological aspects of psychiatry. In 1915 he married Janet Palmer Poulton, who died four years later. In 1920 he married Edythe Dorton, and they had four sons.

SIR JOHN GORDON GOODHART

Sir John Gordon Goodhart, Bart., died on the 13th January, 1979, aged 62 years, after bearing a sad illness with great fortitude.

John was educated at Rugby and Trinity Hall, Cambridge, before going to Guy's Hospital and qualified in 1941. In this respect he followed his father and his uncle, as well as his great uncle, who was awarded the Baronet at the Coronation of King George V. John did his House jobs as an O.P.O. and House Physician at Guy's Hospital before going into the Navy. In 1947 he joined another Guy's Hospital member, Dr. W. S. Hunt, in practice in Bromley where he was to become a respected member of the community. He was elected to the Local Medical Committee for South East London and Kent by his colleagues and eventually to the Executive Committee. When the National Health Service was reorganised in 1974 he was made Chairman of the Bromley Local Medical Committee and served on many of the committees that mushroomed at that time, including the most arduous Area Medical Team. John took it all in his stride in an easy and relaxed way which was typical of his attitude to life, and he had no enemies, only friends. They all miss him and we offer Lady Goodhart our deepest sympathy in her loss; as well as his son, Robert, and daughter, Ann, both of whom qualified at Guy's Hospital and will, I am sure, keep the name of Goodhart in the future, amongst those on the Guy's Hospital Register.

W.VA.

Dr. PETER M. F. BISHOP, D.M.(Oxon), F.R.C.P., F.R.C.O.G.

Dr. Peter Bishop died on 19th January at the age of 74. He will be remembered at Guy's with the greatest affection as the Warden of the College and Deputy Superintendent throughout the war years. He was also the man who established gynaecological endocrinology in this country.

Peter Bishop was the son of a doctor and was educated in Berlin, Charterhouse, and Trinity College, Oxford before coming on to Guy's Hospital Medical School. From then onwards he was very much a part of Guy's. He was the mainstay and chief factotum of the annual residents' play over a considerable period and took impish delight in the fact that he was often mistaken for Noel Coward at that time. He was an excellent teacher and, having started as a physiologist, became Endocrinologist to Guy's and to the Chelsea Hospital for Women, where his fertility clinic attracted visitors from all over the world. To those who worked with him he was kindness itself, as former pupils in all parts of the world can testify. He was Endocrinologist to the Obstetrics Department of the Royal Postgraduate Medical School, Sims Travelling Professor in 1964, Senior Medical Consultant to the Family Planning Association and, in the year of his retirement, Master of the Society of Apothecaries.

The main achievement of Peter Bishop's career was the establishment of gynaecological endocrinology as a new specialty. Encouraged by Frank Cook, the gynaecologist, he carried out meticulous work on a variety of oestrogens, and at the invitation of the Therapeutics Trials Committee of the M.R.C. he conducted the earliest clinical trials of the first synthetic oestrogen stilboestrol. He was well aware of its potential side effects and warned in 1939 that "we may expect some more surprising effects than nausea and vomiting from the promiscuous use of this compound". While his studies led to combined forms of treatment from which the contraceptive pill was eventually developed, his warning about high doses proved prophetic.

Peter Bishop's retirement was unfortunately marred by a cord compression, which he bore very cheerfully but which confined him to a wheelchair for the last years of his life. He is survived by his wife, Phyllis, and by their three children.

M. H. L.

FRANK SUMMERS, L.D.S., R.D.S.

Frank Summers, L.D.S., R.C.S., who qualified at Guy's in November, 1954, when he was 50 years old, died on December 3rd in New South Wales, Australia.

He served in the Code and Cypher in the R.A.F. enlisting at the beginning of the war. His Unit was seconded to General Bradley's H.Q. and the three officers including Frank Summers were awarded the bronze star.

He commenced his training when he was back in civilian life and his elder son Frank qualified at the London Hospital within the same month.

He went to Australia in 1970 and had just returned from a trip to the U.K. on October 23rd.

Janet Summers

Clubs' Union News

My first item of news must be to appologise for my absence during the A.G.M. held on February the eighth due to a very untimely and rather debilitating bout of "flu". However I understand Mark Powlson chaired the "new comers" half of the meeting to the general satisfaction of all, which of course is no mean feat. It is a pity that the meeting did not remain quorate for the whole of the business but this must indicate that just over an hour a term is too much to ask even 10% of the student body to devote to the administration of their union. I intend to explore the possibility of holding at least the A.G.M. during the morning or afternoon at a time that is deliberately set free from pre-clinical teaching, but the fruition of that plan will only become apparent in one year's time.

Let me remind you who the new officers are: **Mark Powlson, Vice-President; Deb Brooke, Secretary; Richard Horne, Social Secretary; Bob Long, Bar Secretary; Tony Vaughan, Ordinary Member; Chris Donovan, Pre-Clinical Member (Medical); Andy Girling, Pre-Clinical Member (Dental).**

When the constitutional amendments come into effect, after having been approved by the board of governors, which will probably be in mid June, Tony Vaughan will become the dental vice-president, and Mark Powlson the medical vice-president. All of the above are readily approachable and if we can't help with your problem or make use of your advice we ought at least be able to pass you onto someone who can. You can contact us via the Boland House notice board or you will find the Union Office manned most lunch hours and at many other times besides.

The Union Office on the first floor of Boland House is also the union shop and one of the things we are trying to organise is an adequate stock of sweat shirts and other paraphanalia, in the near future we intend to expand the range of goods offered but this is difficult at the moment because we are constrained by lack of storage space.

One of the major U.L.U. campaigns has been and will no doubt continue to be on the problem of student accomodation in London. To assess the situation with regard to Guy's students we are preparing a questionnaire which will give us some idea of the scale of the problem, as well, we hope an inkling of what are your preferences with regard to accommodation. On the replies to this survey we will base our actions.

The Summer Festival is already being planned by a small group of us and any suggestions for suitable "sports" or entertainments will be most welcome.

Finally I must turn to a serious and rather disgusting problem that has recently been plagueing the student bar. This is the theft and breakage of glasses. At the last count no less than 673 beer glasses had gone missing. Should a loss on this scale continue we will introduce plastic glasses and if that does not suffice, your bar will be closed. This is no idle threat and though I do not want to harp on the subject, it is up to all the people who use the bar to ensure that this vandalism does not continue.

So in summary, all the new union officers are settling in well and have a large number of more or less viable plans most of which are still at the "feasibility study" stage but if anyone has any useful ideas, or any problems they should feel free to approach us; perhaps we can help each other to put things to rights!

Chas. Newstead,

President Guy's Hospital Clubs Union.

Appreciation

Mr. RAY NICHOLS

With the retirement of Mr. Ray Nichols, Chief Technician of the Inter-Departmental Laboratory, a well known figure has left Guy's. Although interrupted by the war, his service in the Guy's Laboratories dates back to 1935, when he first arrived from school at the age of 14.

Mr. Nichols spent the war first as an aircraft chief inspector and later as a volunteer in the Sick Berth Branch of the Royal Navy. After that he went to Bristol University to work in Physiology and Pharmacology. He moved back to London to become Technical Assistant to the Reader in Physiology at St. Mary's and from there to Goldsmith's College where he was Technician-in-Charge in the Chemistry Department. For the last 15 years he has been back with us, keeping the Inter-Departmental Laboratories going, first in their original home in the old Dental School, then at the end of the Department of Medicine corridor, and finally in their impressive new quarters on the 17th floor of the Tower, where he also had responsibilities in the Clinical Science Laboratories. He became very interested in the Trade Union Movement and defended his junior staff in all circumstances, often more staunchly than they realised. It was his firm view that, in the end, the best results could be achieved by moderation, and he did a great deal to maintain the family feeling at Guy's during difficult times.

Mr. Nichols' many friends were saddened when he suffered a stroke which kept him in hospital for some months and finally made him decide to retire early. Our best wishes go with him and with his wife, Margaret. We hope he will enjoy better health and continue to gain strength in his retirement.

M. H. L.

Career Guidance at Guy's?

by **WESLEY SCOTT-SMITH**

Perhaps one of the salient features of contemporary Medicine is the prodigious diversity of specialities open to the graduate—enough to suit everyone's taste. Undergraduate curricula now contain an increasing number of these specialities, and hence, the chance of arousing a prolonged interest in a subject in any one student, continuing up to graduation and hopefully beyond, is inevitably increased. But, how can such students gain further knowledge of their intended speciality at an undergraduate level in preparation for qualification?

This question encompasses not only the subject of speciality career advice, but also practical questions such as how to choose house-jobs (assuming one has the choice), how to attain places on vocational training schemes, and requirements for postgraduate study and examinations. Speciality career advice or "medical counselling" is not something Guy's students will be particularly familiar with since we have no such formal system. We are not alone, however. Naturally, the "lead" in this field comes from the States where many counselling systems are in operation already. Those without advice systems are in a minority.[1] Although counselling is the vogue, many authorities still believe that it is up to the individual student to initiate discourse with his peers concerning a future career speciality, and others remain steadfast in the idea that at the undergraduate stage it is too early to make a definite decision on a career speciality. Therefore, is there indeed a need for undergraduate medical counselling?

The response from our American contemporaries would appear to be favourable, but two very valid questions arise from the reviews on

this subject: the first was briefly mentioned above—do undergraduates make career preferences early on? The second—is it wise to make these preferences before sampling "working life" in these specialities? Various studies[2, 3] have shown that over 25% of students remain stable in their career preference throughout their time as undergraduates. But, do these students retain their choice after experience from pre-registration house-jobs? This point is amply illustrated by a survey on Manchester and Sheffield graduates from pre-registration status to two years later, which showed that 65% had retained their original career choice.[4] Factors involved in the change of mind regarding speciality choice were reappraisal of aptitude, altered domestic circumstances, additional knowledge of promotion and prospects and additional experience of their new career. The third point is obviously where career advice may be advantageous and it is interesting to note that in one particular study[5] as many as 65% of a group of medical postgraduates felt that their previous career advice had been inadequate.

Assuming that there is a demand for careers advice for undergraduates, what alternatives are available? Firstly, there is an extension of the tutor system used in many schools today which could be expanded to include career advice. Ideally, tutors should be well versed with modern trends in postgraduate Medicine and employed in one of the "mainstream" specialities in Medicine which would provide them with suitable "contacts" in other popular branches of medical life (i.e. General practice, Surgery, General Medicine, Obstetrics & Gynaecology, and Paediatrics). Hence, if they cannot help a student directly, they would be able to refer him/her to a colleague in the appropriate speciality. This type of system has obvious flaws in that it entirely depends on the availability and interest of the tutor towards the problems confronting his student(s). Great dissatisfaction has already been expressed about the tutor systems used at Guy's at B.M.S. level and the discrepancy between individual tutors. If such systems are undesirable, then career advice can be given on a *formal* basis of arranged meetings with staff towards the end of the clinical course, incorporated with discussion about house-appointments. Problems with house-jobs frequently cause concern and insecurity amongst final year students and such a system could help to alleviate these problems considerably. On balance, in view of the poor "track record" of tutor systems, a formal system of careers advice seems preferable.

Perhaps, with one of the above systems in operation, students who have developed an interest in a speciality may secure further relevant knowledge about that speciality, vital to future decisions before unfortunate mistakes are made. Until undergraduates know what alternatives are open to them, they will remain unable to come to a sensible decision about their own futures. However, one wonders when British Medical Schools will come around to this way of thinking and follow their American counterparts, who this time appear to have the right solution.

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Medical Care in an African Urban Area

by Dr. **JOHN COOK**

Bulawayo is the Capital city of Matabeleland and the second city of Rhodesia. It is a focal point in communications, being the centre of Railway communications, an excellent road system and with an International Airport. The city is an industrial centre, having Light Engineering, Furniture manufacturing, Clothing, Radio and Television factories operating within the city. Matabeleland is an agricultural area which has its centre in Bulawayo, as do the various mining complexes situated there.

The African population is estimated at 280,000 with half that number being below the age of fifteen and the majority of this number being under five years of age.

Medical care in the African suburbs is provided by eight multipurpose Clinics, situated in such a way that no patient has further than one mile to walk to the nearest Clinic and many of the residents live within one mile of three different Clinics.

Primary medical care is afforded to all the population but, the predominance of children in the population demands that interest be given to those under five years old in setting up Paediatric Clinics, having an emphasis on Preventive Medicine and the Promotion of Health in the pre-school child. Immunization procedures are carried out in the first year of life to protect against T.B., whooping cough, diphtheria, tetanus, measles, poliomyelitis and, the number of children completely immunized at the age of one year, is in the region of 90—92%. The children visit the clinics regularly for weighing and checking and at the age of five years, have booster doses of triple vaccine and B.C.G. This is prior to school entry. B.C.G. is offered to school leavers and rubella vaccine to adolescent girls.

Children who default from attendance for follow-up are visited at home by a Health Visitor Nurse. Attendances at paediatric and well-baby clinics number in the region of 9,000 per month at each centre. A close liaison operates with the Paediatric Department at the Mpilo Central Hospital, which is situated within the African suburbs. The standard of health maintained within the child population is good.

Four of the clinics are equipped as maternity centres with a total of 60 maternity beds. Deliveries total 3,600 per year. Ante-natal clinics are held at each of the eight clinics and the patients are afforded the choice of clinics where they may attend for delivery. Patients are discharged within 48 hours of delivery and are visited at home by midwives who carry out post-natal follow-up and treatment at home for 7–10 days. Post-natal check of the mother and child is carried out at six weeks after delivery and the baby is registered in the well-baby clinic. At the post-natal examination a cervical smear is carried out routinely on all para 4 mothers and, in cases where the cervix appears unhealthy.

Skimmed milk powder, full cream milk powder, protein dietary supplements and vitamins are provided at all clinics.

The crude birth rate is estimated at 48 per 1,000 and the crude death rate at 14 per thousand head of population. This leads to a high rate of population increase, 3.6% per annum, which tends to a doubling of population every twenty years. This gives rise to a need for provision of family planning clinics and these operate regularly at each of the medical centres. Some 7,500 ladies of child bearing age are actively engaged in family planning.

Each clinic has a large hall which is used twice daily for lectures to promote good health among the population. Subjects covered by these include, baby-care, home nursing, good dietetics, family planning, home hygience and all are well attended.

Treatment is afforded for all minor ailments and injuries. Access to the Central Hospital at Mpilo is readily available to those suffering from a more serious ailment. Follow-up treatment is also avaliable for patients having industrial injuries who have their initial treatment at clinics operating in the factories. The clinics are well equipped and staffed by qualified medical personnel. These include a senior sister in charge, two junior sisters and a health visitor. They are assisted by 12 to 16 nursing assistants whose duties are divided between the clinics and home visiting. Those in the clinic operate the various clinics which are held daily and the nurses on home visits do follow-up of defaulters, T.B. follow-up, absentees from family planning clinics and immunization clinics, they are also responsible for post-natal follow-up of mother and baby.

All children have a medical examination, prior to school entrance at six years of age or before being accepted in one of the many day-nurseries operating in the suburbs.

Breathing Infants

by P. J. M. OPENSHAW, B.Sc.

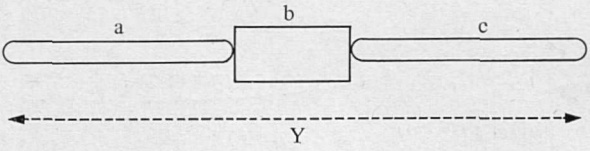
Since the discovery of the importance of alveolar surfactant to breathing, assessment and treatment of respiratory illnesses in infants has undergone a virtual revolution. The attention of clinicians has been focused on the alveolus, and therapy has been directed towards preventing alveolar collapse by increasing the airway pressure and maintaining oxygenation of the blood by raising the alveolar oxygen concentration. The other components of the respiratory system have seemed of lesser importance.

There are other features of the respiratory system of an infant which also deserve special consideration. Firstly, the skeleton of the thorax consists largely of cartilage at birth, and is quite flexible. Secondly, in adults the ribs rise during inspiration and the thorax increases in diameter (the "Bucket handle" mechanism), whereas in infants the ribs lie horizontally so that this mechanism cannot operate.

Both these factors are thought to reduce the mechanical efficiency of thoracic breathing in infants (Crelin, 1973).

Although the change in geometry of the rib cage with age has been known for many years (Howard and Bauer, 1949), the position of the ribs has not previously been quantified, nor has the change with age been observed in detail.

Radiographs of children attending casualty for minor complaints involving the chest were selected for study. The children were generally well in other respects and only well orientated normal films taken at good inspiration were used. A ratio was derived for each pair of ribs which was related to the mechanical advantage of the bucket handle mechanism, and corrected for the separation of the necks of the ribs



$$\frac{a + b + c}{Y} = \text{Inspiratory Ratio}$$

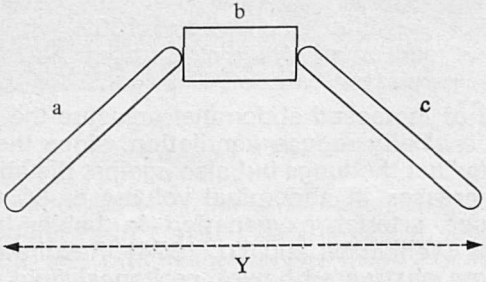


Figure 1

These diagrams show the method of calculation of the "inspiratory ratio". The upper diagram represents a vertebra and part of ribs from a child, with a ratio of 1. The lower diagram is of a vertebra and pair of ribs of an adult, with a ratio of about 0.8.

(see figure 1). A ratio of one implies that the ribcage is already fully expanded, and that air cannot be drawn into the chest by raising the ribs. The change of this ratio with age is illustrated in figure 2. The

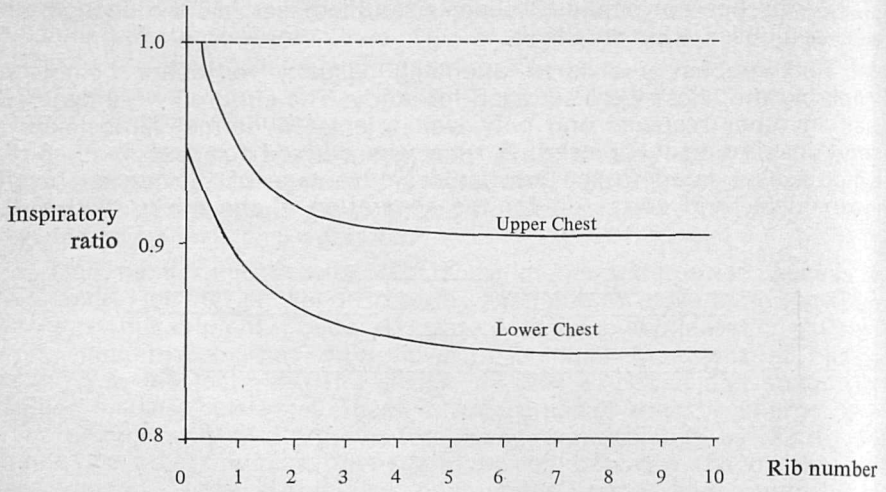


Figure 2

The inspiratory ratio normally decreases with age, and is higher in the upper (ribs 2-5) than in the lower chest (ribs 7-10).

results confirm that the mechanical advantage of the bucket handle mechanism is reduced in children less than a year old. In a small number of additional radiographs studied of children with repeated chest infections or chronic respiratory disease, it appears that the infantile pattern is retained in later childhood.

In adults, any impairment of thoracic breathing can be compensated for by an increase in activity of the diaphragm. In infants the function of the diaphragm is apparently not fully developed during the first few days of life (Miller and Behrle, 1952) so that any change which increases the load on an already compromised respiratory system may quickly lead to respiratory failure.

In conditions of increased abdominal pressure the load on a failing diaphragm might critically reduce ventilation, since the diaphragm has to work not only against the lungs but also against the abdominal viscera. Even moderate increases in abdominal volume of 10 to 20 ml during feeding can reduce arterial oxygenation in babies recovering from respiratory distress (Wilkinson and Yu, 1974). Respiratory failure might similarly result from obstructed bowel, peritoneal fluid or an abdominal mass.

One simple way in which the load on the diaphragm might be lessened is to nurse a baby sitting up. Such a change in posture would be expected to improve breathing irrespective of the cause of respiratory difficulty. Equally, holding an infant upside down would increase the pressure on the underside of the diaphragm and might stop it

breathing. It is therefore not unusual to see an infant vigorous whilst being carried by a midwife, but apnoeic when placed on a resuscitation trolley, head down for mucus aspiration.

The suggestion that babies at risk of respiratory failure should be nursed upright is not wholly new. Dr. Annie Clark* (1844-1924) was one of the first women in paediatricians in this country. To quote from her obituary in the Lancet of 1924:

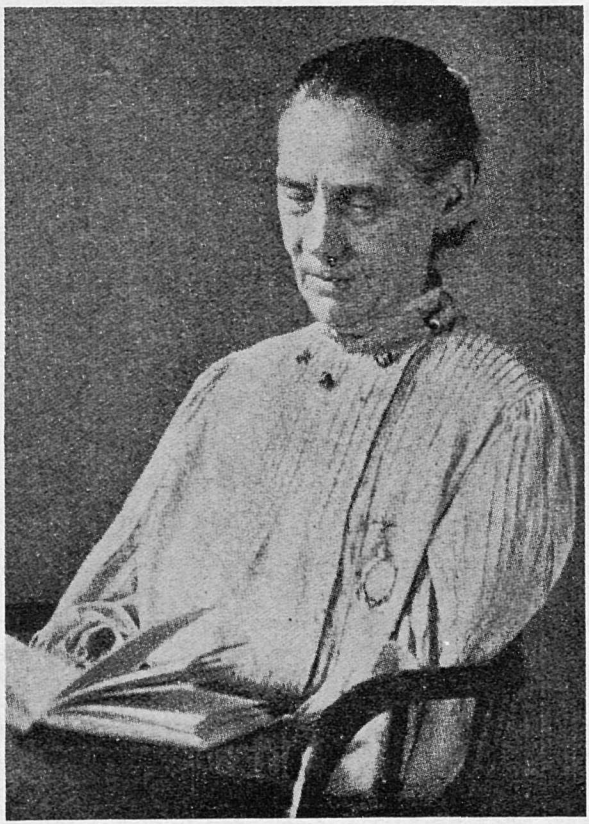


Figure 4

Annie Clark (1844-1924).

> "Not richly endowed with the gifts and graces which make it easy to gain popularity in social life, she had a sure instinct for what was possible and practicable in any given household. 'She always seemed to know exactly what to do', her patients said of her. . . ."

From her experience of managing babies with pneumonia she developed the strong opinion that babies should be nursed at home by their mothers, who held them upright in their arms. In hospital, they were laid flat in a cot and quickly succumbed. The present sug-

* *My great-great-great-aunt.*

gestions therefore provide a physiological explanation for the teachings of Annie Clark, forgotten after nearly a hundred years of improvements in the management of respiratory failure in infants.

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Peter Openshaw has been awarded the Beddard Prize by the Pupils Physical Society for his recent presentation of this paper.

"Issues in General Practice" Contributions should be sent to The Editor, Guy's Gazette, 16 St. Thomas Street, SE1 9RT.

Seal That Gap

(Is the gap between the hospital doctor and the family doctor adequately bridged?)

by CYRIL JOSEPHS, M.D., F.R.C.G.P., D.C.H.

I qualified in 1943 and although it seems like yesterday, there were still two years of war to be endured and five years to go before the inception of the National Health Service, which was to be the panacea and "the envy of the world". Few would deny that the N.H.S. allowed medical care to make great strides: I carefully avoid stating that it made great advances, because I have niggling doubts as to how many of the strides have been forwards, how many backwards, and how many merely marking time. In the final anaylsis, one would like to believe that the patient (surely the only person who really matters) gets better care today than he did before the N.H.S. I wonder whether he does. I could give a formidable list of instances which at least cast doubt on this premise, but must content myself with offering a few seemingly controversial issues for contemplation. Are the waiting lists for admission to hospital shorter? Is waiting over three months to see an orthopaedic surgeon in outpatients acceptable? Is it an advance to develop a highly successful hip prosthesis and then preclude the elderly, whose need is the greatest, from even being entered on the waiting list for admission because they are likely to die before ever being admitted? Do the very expensive and highly sophisticated coronary care units save more lives

than hitherto? We must eventually realise that the demands made on an open-ended Health Service are, and will aways be, insatiable.

To me this theme is fascinating. I feel often as though we are hurtling ever forwards at greater speeds; manufacturing at least as many problems as we solve and losing sight of many of our priorities on the way. When a doctor told his patient that he honestly was not really worried about the patient's blood-pressure, he was taken aback when he received the reply "I'm sure you're not. It's *my* blood-pressure, not yours." How often, even allowing for the advances in medical therapy do we make the treatment worse than the disease, and how much time and money do we waste treating conditions which would resolve if left alone? I could continue in this vein. But I am taking the easier way out and diverting my thoughts for a while to the vexing question of the gap between the hospital doctor and the family doctor. Did it exist in the past? Does it exist now, or are we at last of the same breed? Before the N.H.S. the medical student received all his teaching from consultants in the hospital environment. (That is not quite true because I well remember having two very dull lectures of one hour each from family doctors on the subjects of issuing "sick" certificates and on mental certification before removal to an asylum. The only contact I ever had with a family doctor [apart from when I was ill] during five years medical training was for two hours. And that was at a time when a student could qualify one day and go into practice the next day and spend his life there. Many did just this.)

The medical student then knew vaguely that there was a world of medicine outside "his" hospital but he had no more idea of what it was like than most of us have of the moon. He knew there must be administrators somewhere, but was content to take for granted that the hospital ran continuously and smoothly on its own. His chief was a person of incredible skill and unquestionable infallibility: the G.P. was of another tribe; a disembodied person who somewhere and somehow had written a referral letter and whose existence cropped up once more when the houseman had to write the discharge letter. The gap that existed then was limitless: the G.P. and the hospital doctor were quite definitely different animals belonging to different worlds and the bridge between accommodated almost entirely one-way traffic; from the hospital to the outer world of general practice.

Thus we have obviously advanced enormously. Family doctors now abound in hospital, working as clinical assistants. The medical student spends more of his time with the G.P. and receives some of his teaching from him. Vocational training, soon to be compulsory for those wishing to become principals in general practice, and the Trainee Scheme have given young doctors a chance to get a good groundwork in general practice. Family doctors sit with consultant colleagues on hospital committees and take an active part in administrative matters.

Thus I should be content in the knowledge that the gap has been bridged: that we are all of one class and work together, hand-in-hand. Again I have niggling doubts that this is not quite so. When my patient goes into hospital I hand over his care to the consultant. *He* is now *my* disembodied doctor who writes to me—eventually, if I am lucky. We still seem to have a real fence between us. We welcome the patient's

return to his home as we welcome members of our family who have returned from foreign lands. Hospital is a foreign land with quaint customs manned by caring, highly efficient staff who are nonetheless foreigners. Even the language spoken is foreign.

The routine in hospital is as different from one's normal routine as is driving a car on the other side of the road from one's own. The consultant, for his part, relinquishes responsibility for the patient when he is discharged. In fact the responsibility goes to and fro like a tennis ball over the net—but the net is an opaque wall which effectively stops the two players seeing each other's activities.

I believe that the gap between the two brands of doctor still exists, although there have been a few tentative bridges erected. There is a growing number of instances in which senior consultants are holding regular clinics in general practice. It is very noticeable what goodwill such attendances engender and I am sure patient-care is the better for this close relationship. It is essential for the more senior hospital doctors to go even further in understanding the role and the work of the family doctor if only because so many cannot possibly achieve a career in the hospital service in the N.H.S. At present in England and Wales there are nearly twice as many junior hospital doctors as there are consultants. Thus, as the structure exists today, almost half the aspiring consultants will have to leave hospital for general practice or find other medical work, here or abroad.

Since I qualified over thirty years ago I have seen the pendulum swing the other way. The swing is away from hospital care to community care, and far from bemoaning this fact I applaud it. General practice is emerging with ever increasing momentum as a very worth-while speciality with exciting career prospects and an ever increasing responsibility for medical care. The general practitioner today is a completely different creature from that of thirty years ago. He now takes an active and significant part in the teaching of postgraduates. He has his own postgraduate examination. In recent years he has taken to writing his own textbooks—something quite unimaginable in the past, and has journals written by his colleagues in his own language offering every facet of postgraduate learning.

Sometimes he even writes for a hospital journal. Perhaps there is hope yet of sealing the gap.

Guy's Hospital Gazette

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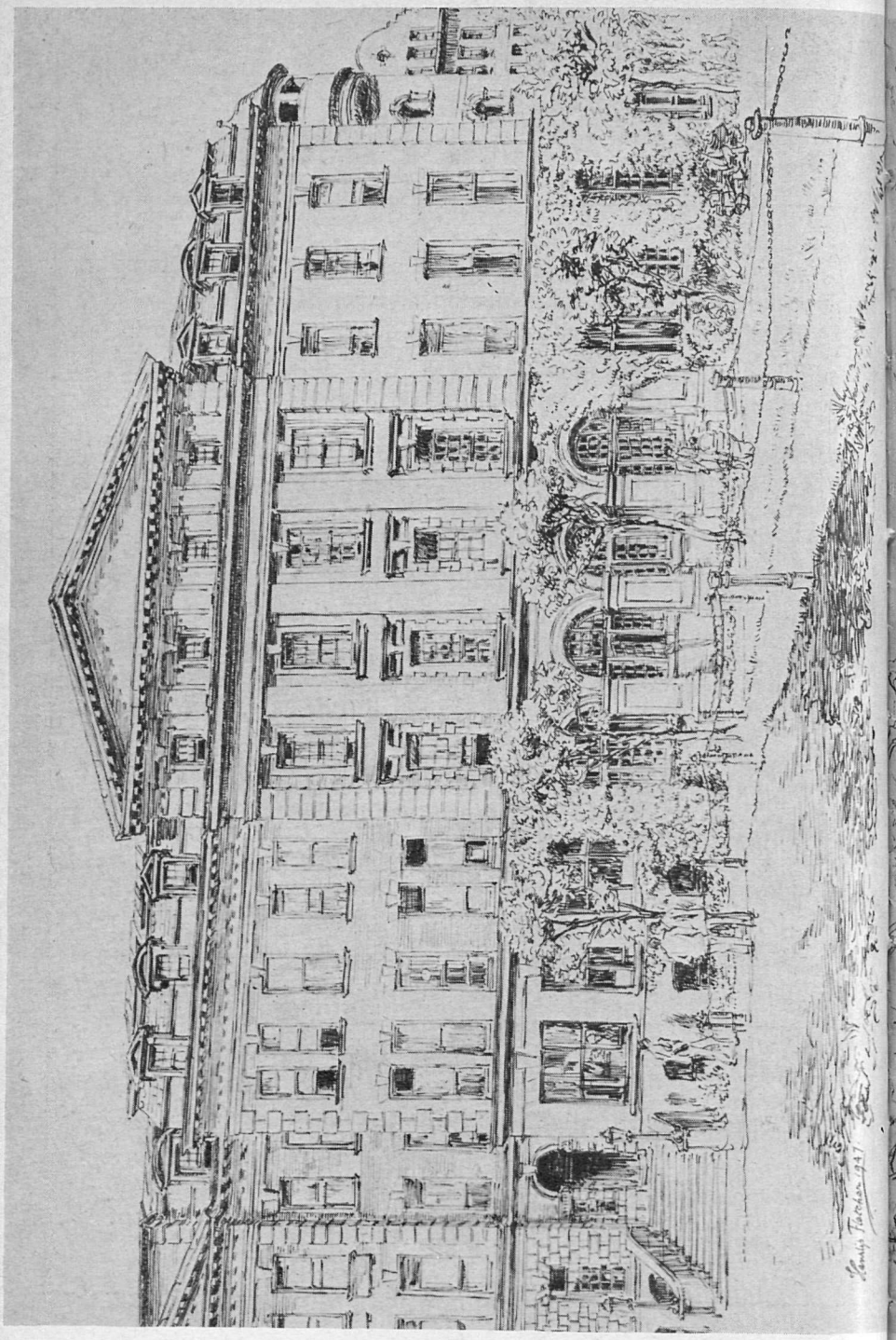

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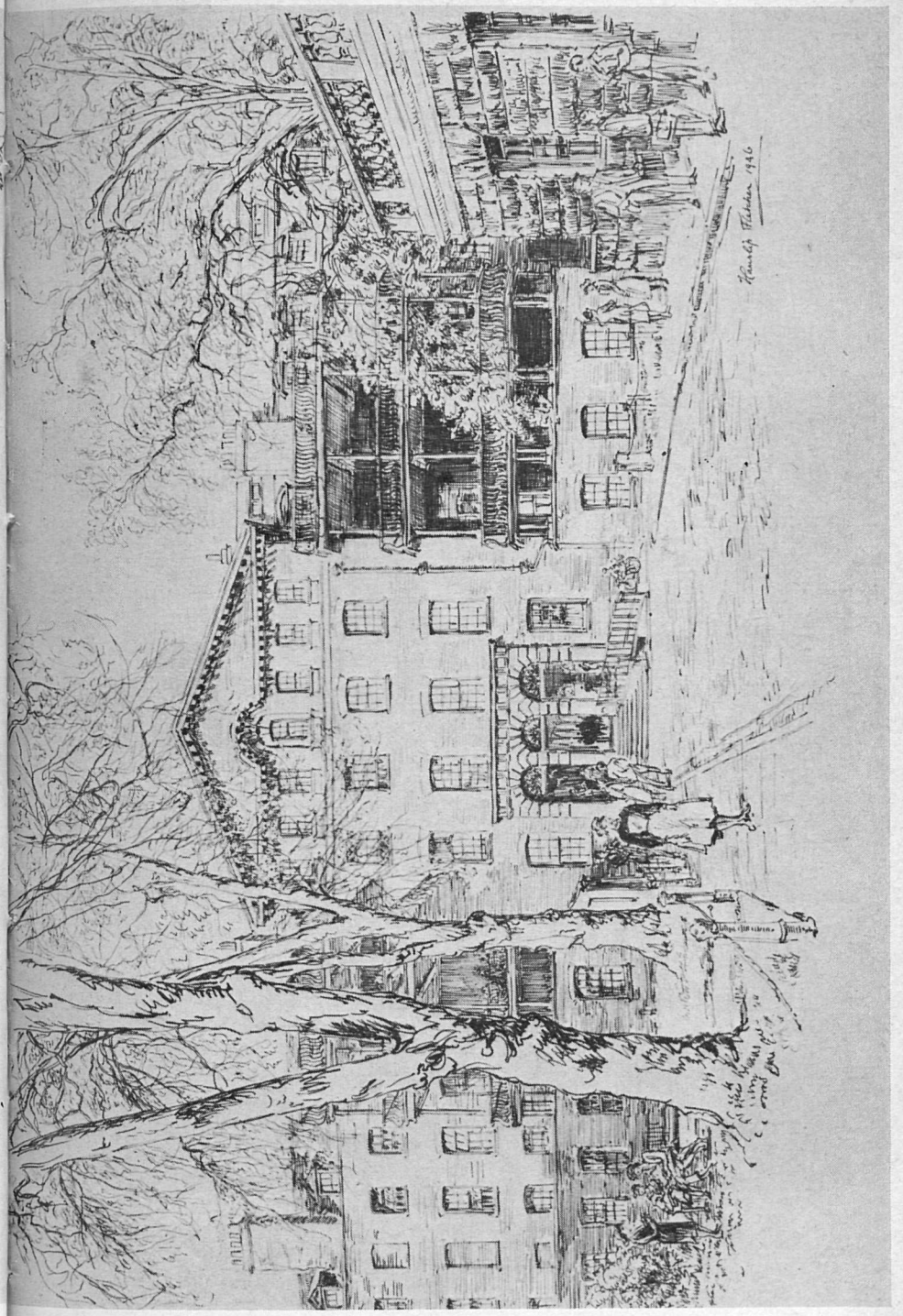

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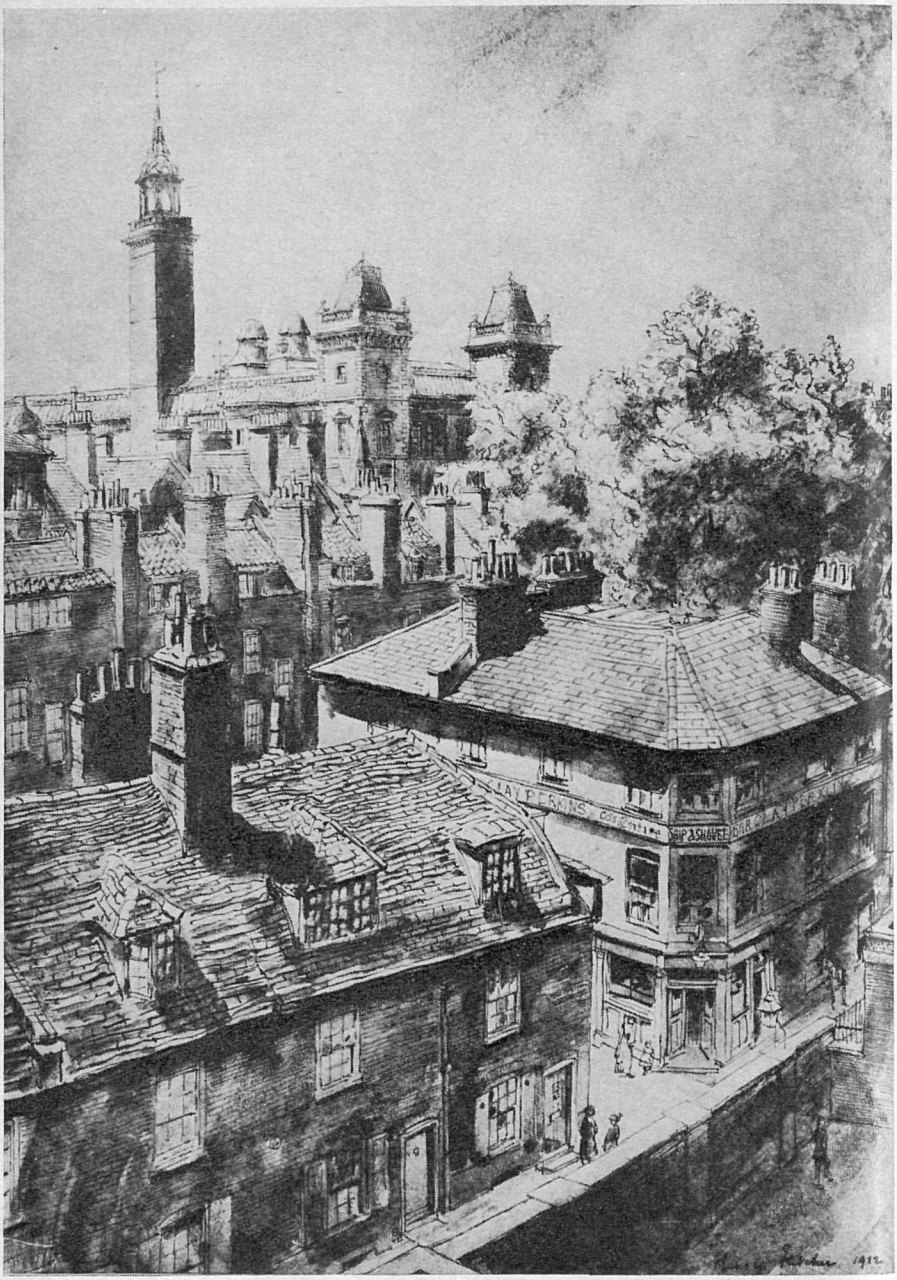

"The Ship and Shovel" 1912

A History of Guy's Hospital Rugby Football Club - 4

by Mr. T. L. T. LEWIS

Rebuilding with Popplewell

"Pop" (J. R. F.) Popplewell was faced with re-building the side for 1927–28 with some good material at his disposal, five teams playing regularly every week at Guy's. V. G. Boyle, P. D. B. Spence, A. J. D. Lewis and F. H. B. Spence were available as were Victor Preen and Tommy Garland, whose tall and frail-looking build did not prevent him from stealing round the scrum to score as many tries as any other scrum-half at Guy's. "Pop" Myburgh, A. Simpson-Smith, J. H. Cullinan, John Durr, C. D. Malone and G .G. Cameron were still at Guy's and B. G. Scholefield had returned after two years in America. Of the newcomers were D. F. Ryan from Cambridge, and a Welsh trialist three-quarter, T .G. Robinson (wing three-quarter), R. J. Eustace and I. K. Thomas (scrum and stand-off), T. Morgan (a wing-forward from Penarth) and R. A. P. (Rusty) Hogbin, an Old Pauline, who was to play a big part in Guy's rugby in the next few years.

Nevertheless, the season was a disappointing one, only twelve matches won out of twenty-six. These did include wins over the unbeaten Llanelli (14—3) at Honour Oak Park, the first time we had played them since 1913, Harlequins (3—0), London Scottish (12—0), Blackheath (9—3), and Gloucester (6—3). We were narrowly beaten 9—8 by Bristol away, in front of 10,000 spectators, the forwards playing the game of their lives. P. D. B. Spence made a great name for himself at full-back, fielding and kicking beautifully. Eight members of the team played in county matches. Tommy Garland was travelling reserve for England against Wales. To everyone's surprise Bart's beat us 5—3 in the semi-final, a defeat apparently so deeply felt that there is not even a report of the game in the *Gazette*.

Windsor Lewis and J. S. Batchelor

T. O. Garland was elected to be the 1928–29 Captain, but due to illness his place had to be taken by J. R. F. Popplewell, who was able to welcome the brilliant Welsh International stand-off half from Cambridge University, Windsor H. Lewis, and a forward from Otago University, New Zealand, J. S. Batchelor (later Orthopaedic Surgeon to the Hospital and President of the Club since 1960). Owing to injuries the first half of the season was disastrous, only two games being won out of fourteen. In the second half, however, wins were achieved at Kirkenhead Park (14—8), Guy's being the first side to beat them on their own ground that season; against Gloucester (14—0) and against Rosslyn Park (13—3). The game against the Park was memorable, for prior to meeting Guy's they had twelve successive victories to their credit, and their defeat was all the more remarkable because G. F. Lashmore broke a rib in the first few minutes and Windsor Lewis had to retire injured in the

second half. Two newcomers from South Africa were in the Guy's pack. T. Fichardt from the Transvaal and J. Kunovsky who had played in the front row for the Combined Cape Town-Stellenbosch Universities XV which defeated the All-Blacks in 1928. Guy's other achievements were to draw 18—18 with Cambridge University and to win the Cup by defeating the London 3—0 in the final. "Pop' 'Myburgh played for London in Germany against Hanover before he left for South Africa. Popplewell was selected, but could not play. Later in the season he played for London against Paris. Top try scorer during the season was T. G. Robinson on the wing with eleven, followed by a forward, Tommy Morgan, with six; Oliver Ive played in six matches and scored in five. R. A. P. Hobgin, who was to become a prince of place-kickers, converted twenty tries out of fifty-one and kicked three penalty goals.

1930's

The 1929–30 season was moderately successful and although we won only 12 games out of 28, we scored more points, 322, than were scored against us, 311. T. G. Robinson, by now an Irish trialist, was an inspiring captain and played on the right wing. It was being appreciated at Guy's with a certain amount of apprehension for the future, that St. Mary's Hospital were out to capture as many promising games players from Public Schools and from the 'varsities as they could. Birkenhead Park were beaten twice (11—6 and 19—4), U.S. Portsmouth (24—6), and Aberavon (on their own ground, 9—6). With a mid-field triangle of J. E. Giesen from New Zealand, the Welsh International Guy Morgan, late captain of Cambridge University, and Windsor Lewis, there were great hopes for success. "Rusty" Hogbin a powerful back-row forward, was creating such a good impression that many were wondering why he was not in the England side. During the season he played in 27 games and scored 75 points, 3 tries, 24 conversions and 6 penalty goals. At full-back, Lewis Wailer, who had played for Durham, was an accurate touch-finder and a fearless tackler. He took over from T. A. Hale-Monro and D. F. Ryan (Welsh and Irish trials). Robinson's centre was either J. E. Giesen, T. Fichardt or H. J. B. Atkins (now Professor Sir Hedley Atkins, President of the Royal College of Surgeons). On the other wing were A. G. Johnson or A. J. D. Lewis and W. Guy Morgan, or I. K. Thomas in the centre. Windsor Lewis or Gieson and J. Howell or R. J. Eustace were the halves. The pack consisted of J. R. F. Popplewell, D. S. Clogg, J. P. O'Shea, J. S. Batchelor, C D. Malone, T. Morgan, J. Kunovsky, L. I. S. Campbell, K. P. Smith and A. R. Clarke. Three players were selected for the Barbarians Welsh tour, Popplewell, Windsor-Lewis and A. G. Johnson; and three played for London against Paris, Popplewell, Gieson and Johnson. Johnson was the find of the year, a wing who possessed speed, swerve and a willingness to go for the line. "Pop" Popplewell had been playing regularly for Guy's since 1924; six foot one and thirteen stone, he was a great back-row forward, always doing something vigorous and thrustful. His qualities as a leader were of the greatest value to Guy's. He could be easily heard or understood, knew how to control or encourage and how to change tactics. Altogether he made 163 appearances for Guy's including four cup finals. This year the cup had special significance being the 50th inter-hospital competition. So far Guy's had been in twenty-nine finals, winning twenty-

three. The thrust of our three-quarters made us strong favourites and hope in them was justified by the 18 points they scored against 9 by Bart's in the final.

Windsor-Lewis was captain for the next two seasons, 1930–31 and 1931–32, with J. S. Batchelor as secretary and then vice-captain. Guy Morgan, sad to say, gave up medicine and left Guy's. Walter Lewis became the new full-back in 1930–31; D. E. Ashdown established himself on the right wing with either T. Fichardt or I. K. Thomas in the centre; A. G. Johnson or G. A. Burrows and Jimmy Giesen forming the left wing. Windsor-Lewis was always ready for the cut-through or drop at goal. At the base of the scrum was R. J. Eustace or J. Howell and in the scrum J. P. O'Shea hooked; J. S. Batchelor, J. Kunovsky, J. R. F. Popplewell, R. G. Knight, T. Morgan, G. F. Lashmore and R. A. P. Hogbin were joined by I. G. Robin and L. B. Hilton. Thirteen out of 28 matches were won; Coventry (33—17), Richmond (9—3), Gloucester (9—3), Rosslyn Park (7—3 and 28—3), and Aberavon (9—8) being defeated. Hogbin continued in his scoring mood, converting no less than 26 tries and kicking 9 penalty goals (79 points). The cup was lost to Bart's 8—0 in the second round; Guy's learned how effective a spoiling game can be with the Bart's three-quarters lining right up and the loose forwards pouncing on every opportunity. In 1931—32 we fielded more or less the same team with the addition of P. C. Alexander, the Oxford Blue, who combined well with Windsor-Lewis, T. Fichardt and J. E. Giesen. We won against Plymouth Albion (9—6). Cheltenham (24—6), Coventry (11—0, Bristol (13—11), Richmond (14—3, Cambridge University (8—3), and the London Irish (26—13). Finally, we won back the cup by beating St. Mary's 16—7 in the final, with a newcomer, C. S. Darke, from Mill Hill School in the pack. R. A. P. Hogbin was again the outstanding success of the side, playing in every game except one, scoring 108 points out of a total of 295 and failing to score in only three of the games in which he played.

Rugby Scholarships

There had been a growing feeling among several Hospitals that the St. Mary's practice of awarding scholarships to games players gave them an unfair advantage and a meeting of the hospital rugby clubs was held to decide whether or not to continue the Inter-Hospital Competition. Fortunately the matter was settled amicably and the 1932–33 competition was played. Most of the previous year's players were available to T. Morgan, the new captain, a popular man and first-rate pack leader. After some experiments W. B. Clegg was played at full-back, C. G. Wright and P. C. Alexander on one wing and J. E. Giesen and A. G. Johnson on the other. I. K. Thomas came in at stand-off with V. H. Bowles at the base of the scrum. A. G. Heberlein, J. P. O'Shea and M. R. ("Gugu") Kark were in the front row, R. J. Drummond and Ian G. Robin were a tower of strength in the second row, while R. A. P. Hogbin, T. Morgan, A. R. Clarke and sometimes C. S. Darke, who also played prop when necessary, made up the back row. M. Walt, D. N. Leeming and T. A. Hale-Munro deputised on occasion in the pack; M. J. Lindsey and D. E. Ashdown at three-quarter. Fourteen matches were won out of thirty games played and the cup was retained. We beat St. Mary's 9—8 in the second round (Hogbin kicked two penalty goals) and Bart's 7—0

in the final. R. A. P. Hogbin continued his wonderful scoring feats by converting 24 tries, kicking 15 penalty goals and scoring 15 tries, a personal tally of 108 points! J. E. Giesen dropped 5 goals and scored 12 tries and A. G. Johnson scored 15 tries.

The captaincy for 1933—34 was in the capable hands of J. E. Giesen with P. C. Alexander as Vice-Captain. Most of the previous year's back division and scrum were available. As the season progressed M. J. Lindsey took over the full-back position from W. D. Clegg and E. C. Sharpe. On the right wing Alexander and C. G. Wright became formidable; Alexander had a tremendous burst of speed with which he beat the defence and Wright had the elusiveness and determination to finish off the movement. They were both rewarded with an England trial. On the left wing A. G. Johnson was a fixture but either Giesen or a newcomer from South Africa J. Van A. Steytler ("Van") played centre or stand off. (He is now the leader of the Progressive Party in South Africa.) D. I. Chapman came in at scrum-half. In the scrum A. G. Heberlein hooked and H. H. Crabb propped with M. R. Kark. Jimmy Giesen had a great season and was selected for the Barbarians' Easter tour to Wales. Fourteen out of 32 games were won, which included wins against Bath (10—8), Rosslyn Park (26—17), London Scottish (21—6) and Aberavon (11—10). Cambridge University beat us 8—6 with the Welsh wizard, Cliff Jones, playing for them.

In the cup, the inevitable eventually came to pass. St. Mary's beat us 11—9 in the semi-final after a replay. There was no score in the first game, but in the second, Tuppy Owen-Smith, the South African, and Chuck Henley, the New Zealander, both from Oxford, were too much for Guy's, and St. Mary's were repaid for their "rugger scholarships". This season was the last one for "Rusty" Hogbin, always conspicuous in the line-outs and the loose play, a superb place kicker, who in all made 172 appearances for the first fifteen during which he converted 158 tries, kicked 60 penalty goals and scored 26 tries; a total of 574 points! From Guy's he went to captain the Old Paulines and he can be seen today acting as touch judge and urging his men on.

Several new arrivals promised well for 1934–35 when I. G. Robin took over the captaincy. This was especially true of R. C. S. Dick, Scottish International from Cambridge, P. Fletcher, a young Cardiff forward, and A. ("Jock") Forbes, C. Ziervogel and G. J. van der Merwe from South Africa. Our three-quarter line of C. G. Wright and P. C. Alexander, R. C. S. Dick and J. Van A. Steytler with J. E. Giesen at stand-off, should have been one of the best in the country. However the team never settled down although they beat Gloucester (18—8), Coventry (6—3), Aberavon (13—6) and United Services Portsmouth (16—8); Only ten out of 30 games were won and the side must be regarded as a big disappointment. To cap it all Bart's knocked us out of the cup 7—0 in the first round by beating us forward and never giving our star-studded three-quarter line a chance. P. K. Hopkins became the regular hooker, E. R. Davies and C. Ziervogel the second row and P. Fletcher, R. O. Yerbury and T. A. Hale-Monro the back row. K. A. Stanyon-Jacques and V. H. Bowles shared the scrum-half position. T. Fichardt returned from South Africa to play centre or wing and R. M. de Gregory, I. McD. Stewart or H. J. B. Atkins deputised. It was the last

season of A. R. Clarke whose unbounded energy and backing up in the tight and the loose had served Guy's so well for five years.

Fire at H.O.P.

On a very hot afternoon on the 21st August 1935, the stand at Honor Oak Park was entirely destroyed by fire. A smaller stand was erected in its place. The playing pitch was properly drained, the Pavilion was enlarged and several hard tennis courts constructed. The opening ceremony was performed on January 29th 1936 by Mr. (later Sir Hubert) H. L. Eason, Vice-Chancellor of London University and former Superintendent of the Hospital, and a rugby match was played against Cambridge University (which we lost 11—3). In the evening a most successful dinner was held to mark the occasion at Grosvenor House arranged by the indefatigable Mr. J. H. E. Winston, Secretary of the Medical School. It was attended by officials of the Rugby and County Unions and many past and present members of Guy's R.F.C.

Under the captaincy of C. S. Darke, Guy's faced the 1935–36 season without P. C. Alexander, J. E. Giesen and A. R. Clarke. The season, as judged by results was again a disappointing one, only ten out of 33 matches being won. We had two Internationals, R. C. S. Dick, who played for Scotland in all their matches, and E. S. Nicholson, who hooked for England against the All Blacks and Wales. Individually the members of the team were above ordinary merit, several playing for their county, but they failed to blend. Costa Halamandres, Universities and Hospitals light weight boxing champion from South Africa, one of a quartet of brothers who were to shine at games at Guy's, was full back. The three-quarter line was C. G. Wright, R. C. S. Dick, J. Van A. Steytler and D. M. Douglas, I. Mc. D. Stewart or R. M. de Gregory; the halves, R. D. Allen and K. A. Stanyon-Jacques; M. R. Kark, E. S. Nicholson and H. H. Crabb in the front row, E. R. Davies and E. B. ("Ted") French in the second and C. S. Darke, P. Fletcher, R. O. Yerbury or E. C. Sharp in the back row. S. M. ("Sam") Whitteridge and A. J. ("Jack") Drew made some appearances. We were beaten in the semi-final of the cup by St. Mary's (the eventual winners) 11—3 largely due to the efforts of two South Africans, Bok and Owen-Smith.

Hopes for 1936–37 were soon to be dashed. R. C. S. Dick took over as captain and all the previous year's players were available. During the whole season we won only seven games. Although forty-two players appeared in the first fifteen, a sign that things were not going well. Newcomers who impressed were W. J. Lewis, brother of Windsor, at scrum-half, J. R. D. ("Digger") Williams in the second row and R. M. Sharpe at the back of the scrum. As the result of a favourable draw we reached the Cup final, only to be beaten again 11—4 by a strong St. Mary's fifteen. The team played well and Van Steytler dropped a goal. The poor results in the first half of the 1937–38 season and the large scores being run up against the 1st XV stimulated the Captain E. S. Nicholson, R. C. S. Dick and H. H. Crabb to write a letter urging immediate action and asking for advice. Many ex-captains and others wrote in to say that not enough interest was being paid to junior teams and that good Guy's players were turning out for other clubs. Dr. Arnold Alcock, the President of Gloucester R.F.C. and former Guy's player and English International of 1906, wrote a heartening letter after

the game against Gloucester. He said that the better side lost, but blamed lack of team spirit and a psychological inferiority for Guy's failure so far. Some improvement followed the arrival at Christmas of Louis Babrow, the Springbok International who toured New Zealand with the South Africans in 1936. It took him some time to settle down, however, and the season's results as a whole, were still poor, eleven games being won out of thirty-six. We reached the final of the cup, but were beaten again 18—0 by St. Mary's. Apart from Babrow, new names in the side included those of J. P. Crawford at full back, R. U. F. Kynaston, former captain of Bedford School, in the three-quarter line and C. Vidot, G. S. A. Sechiari, J. P. Rochford and P. D'O. Kolesar in the forwards.

George Winston

This year J. H. W. Winston relinquished the position of fixture secretary in favour of his brother George. For many years John had maintained a strong fixture list and was a familiar figure at Honor Oak Park helping to entertain our visitors.

It is sad to relate that, in spite of good intentions, fortunes did not change materially in 1938–39. R. C. S. Dick was elected captain but left after a few weeks. C. S. Darke was elected in his place but was only able to play in nine games and L. Babrow took over the leadership. There was some evidence that he was able to rouse the old fighting spirit, Guy's coming back into the game even when many points down, and several keen games were lost by only a small margin. Nine games were won out of thirty-one and we were beaten by St. Thomas's 6—5 in the semi-final of the cup. Once again a large number of players was tried, 42 appearing for the first XV. We find many new names, some of whom were to become well known later. A. E. M. Wiggins was a dashing wing-forward from Cambridge; J. M. Hanson, wing three-quarter, had broken the University of London 100 yards record; R. F. ("Dickie") Camp, another wing, with a rare turn of speed for the line; R. D. Plowman a safe full back, P. C. Gartrell and J. H. Phillips at stand off, the latter having played for Swansea; J. S. ("Johnny") Breen-Turner who took R. C. S. Dick's place in the centre; H. Osmond hooker with D. N. Fuller on one side and C. Vidot on the other; and D. P. ("Paddy") Finnegan, John Bulstrode and Tom M. Renton, forwards.

War Declared

The season 1939–40 was a strange affair. All regular fixtures were cancelled owing to the declaration of war and matches were arranged with clubs who were continuing to play such as Rosslyn Park, Wasps and Metropolitan Police, with other hospitals and with service sides. Guy's students were scattered all over the South Eastern Sector under the Emergency Medical Services scheme, but they were only too happy to foregather for rugby in London on a Saturday afternoon. Louis Babrow was captain. Three South Africans arrived who were to play an important part in Guy's war-time rugby. They were M. R. ("Mick") Mullins and A. G. ("Ally") Albers from Oxford and the writer from Cambridge, who established himself as full-back in place of R. L. Skea. Babrow and Peter Gartrell formed one wing and R. U. F. Kynaston and D. W. F. Charlton the other. J. Van A. Steytler and P. D. V. Harrett from Llandovery School were the halves and Humphrey Osmond hooker, with

Jerry Rochford and A. S. Carruthers as prop. I. R. D. Williams and John Bulstrode were in the second row and Mick Mullins, Ally Albers, and Tom Renton in the back row. Jacky Phillips played a few games at stand-off, a will-o'-the-wisp reminiscent of Cliff Jones, who, were he not so prone to injury, would have made a big name for himself. J. P. Crawford played a few dashing games on the wing and C. S. Darke deputised in the scrum when called upon. Twelve games were won out of twenty-two and for the first time since 1930–31 we scored more points, 300, than were scored against us, 257. The inter-hospital competition was left in abeyance. Roger Kynaston became captain in 1940–41 and 13 games were won out of 25. Dick Camp and Peter Gartrell were particularly successful on the wings, scoring 15 and 11 tries respectively. R. U. F. Kynaston and D. W. F. Charlton were in the centre. D. M. Strathie, Oxford University stand off, not unlike Windsor Lewis in looks and play, was the pivot on which the whole team revolved. He and his scrum-half partner N. I. Scott had an excellent understanding. Peter Harrett had been called up and was in the R.A.F. R. M. Sharpe (who was later to be drowned in a troop ship) hooked and had J. D. Everall and D. N. Fuller, and later A. B. Lee, on either side of him. Two big men, Ally Albers and J. R. C. Matthews (future English international) occupied the second row and Mick Mullins, Charles Vidot and Tom Renton were at the back. We played some excellent games against the hospitals and beat them all except St. Mary's. The New Zealand Army XV gave a fine exhibition of rugby and proved too strong for us. P. L. Brangwin, J. Breen-Turner, W. H. Lillywhite and A. C. Macrae-Gibson played some good games for the side. Mullins converted 16 tries and kicked 6 penalty goals. While the first fifteen was based on London, the A fifteen was run from Farnborough due to the enthusiasm of George MacVicar, Peter Maxted and David Gullick. Another fifteen organised by P. C. S. Campion and W. H. Whamond played regularly at Tunbridge Wells. We reached the semi-final in both the hospitals seven-a-side and the Middlesex County seven-a-side competitions losing 8—0 to Middlesex Hospital and 14—0 to Cambridge University.

With Peter Brangwin in place of R. U. F. Kynaston, who had gone into the Army, Mick Mullins had last season's team at his disposal for 1941–42. That it was so successful was largely due to the captain's inspiring leadership. Mick Mullins followed in the footsteps of his father R. C., who was captain from 1898–1900, and of his uncle H. R., who led the side in 1909–10. The family tradition was further maintained by his playing for the Barbarians for two years in succession. He also captained the United Hospitals and a representative London R.U. XV. He died later tragically from pneumonia contracted whilst on active service in Italy. Guy's won their first seven games, beating Oxford University and Northampton on the way, when they faced St. Mary's. They had scored 125 points to the opponents' 33. St. Mary's had the famous international triangle of T. A. Kemp, E. K. Scott and N. O. Bennett and it was with great jubilation that we won 7—6, following a last-minute drop goal by the writer. The return match will always be remembered by those who saw it for the remarkable way in which Mick Mullins completely stifled Tommy Kemp who was not able to get his famous three-quarter line moving and the way was paved for another narrow victory

for Guy's 7—6. During the season 14 games were won out of 21. G. Hildick-Smith, who later won the British Amateur Squash rackets championship, deputised occasionally for Murray Strathie at stand-off, R. A. Dean hooked when R. M. Sharpe was injured and B. H. Wilshere, R. F. C. ("Sam") Manning, G. M. ("Tubby") Evans and R. R. ("Tris") Wooldridge sometimes played in the scrum. The best victory was probably that against London District which contained several internationals (including Haydn Tanner) county and Rugby League stars (who were permitted to play Rugby Union during the war).

The War Years

D. M. Strathie was captain in 1942–43. Both P. C. Gartrell and R. F. Camp had left for the Navy. Dick Camp had placed in 56 matches for Guy's and scored 39 tries. He was chosen for England in a war-time Services International, but was unable to play because of an ankle injury. Strathie had some difficulty in filling their places because both P. L. Brangwin and J. B. Kyle had to give up through injury. D. R. Edwards and R. H. N. Long were tried, and eventually J. N. Micklem and Angus Macrae-Gibson played on the wings with Neil Macrae-Gibson (his brother) and Strathie himself in the centre, D. C. Boyd deputising. W. H. Lillywhite played at stand off with R. D. Willcock or R. N. H. Vann at the base of the scrum. J. Ebsworth played one or two sparkling games in place of Lillywhite. The strength of the side was in the forwards, however. A. B. Lee became a first-class hooker and had B. H. Wilshere and R. G. L. Brittain on either side of him. Ally Albers and A. Batty Shaw, a newcomer from Oxford University, were in the second row, and Mick Mullins, C. C. Vidot, S. M. Hilton and P. D. Harvey, the find of the season, were at the back of the scrum. When Mick Mullins departed for the South African Army, D. L. Gullick came into the scrum. Twenty-five games were played and fourteen won, for 282 points, against 171. The writer and A. B. Lee were selected to play for Thornloe's XV against the Barbarians. Lee was unable to play because of examinations.

Films

Here are just a couple of movies for you to see in a rather poor month for cinema fans.

Superman has not taken the country by as much storm as the film company had hoped, by and large because it is an anti climax after so much pre-Christmas build up.

You all know the story—but sometimes I wondered if the directors did. I remember that green Kryptonite robs Superman of his powers —it doesn't kill him, as it nearly does in the film, and I'm sure the city Krypton survived in battles after the planet was destroyed. Lois Lane is delicious and Superman is rather more randy than I expected, but it is as Clark Kent that Christopher Reeve makes his name. Kent stumbles and mumbles his way through the movie with a twinkle in his eye, and produces the film's best moments. As he looks for somewhere to change before his first super deed all he can find is an open

telephone kiosk. The plot is abysmal and much of the dialogue weak but the film has its moments and is overall enjoyable. By the way, I couldn't see the wires.

Every which way but loose may lose Clint Eastwood many fans but if taken in the right spirit it can again make for an enjoyable couple of hours. The plot is awful, the acting is much too far over the top and some of the effects extremely unlikely to say the least. The film is a vehicle for an amazingly loveable orang-utan called Clyde with a superb repertoire of tricks and Clint a tough fist fighter chasing his girl across the country. The film has a couple of superb moments such as when they break into the local zoo to find Clyde a bed mate for the night. I just hope that Clint hasn't stopped making the Dirty Harry series!

J.J.E.

Nursing

THE UNREST WITHIN THE HOSPITALS

The industrial unrest in the country had eventually of course, to reach the hospitals. It would be unrealistic to assume that those people who work in institutions which are designed to care for the weaker members of society would be sufficiently philanthropic to refrain from joining the madding crowd in the general hysteria. The phrase "survival of the fittest", has never carried greater meaning than it does at the present time.

So it is then, that in many hospitals, the ancillary staff have withdrawn their labour and as usual, left the nurses to manage not only their own work, but that of all the dissidents. This of course is not a new phenomenon. Whenever there is a dispute in the hospitals, or an adequate service cannot be supplied by non-nursing staff of any discipline, it is the nurses who are expected to shoulder the responsibility. The administrators who guard their positions so jealously, are quite happy to allow nursing personnel to fulfil their function during unsocial hours, since they cannot, or will not provide coverage throughout twenty-four hours. Likewise, when physiotherapists are unavailable, it is the nurses who ensure continuity of care. As regards the ancillary staff, they of course are frequently unable to provide adequate numbers of staff and are quite content to think that nurses will wash crockery, clean floors and act as porters.

During recent years, nurses have been urged strongly to join those unions which have infiltrated the hospitals. It is interesting therefore to observe that these organisations on the one hand seek support in order to increase their numbers, but do on the other hand, expect such people to behave in a truly professional manner. If the nurses were actually to adopt the same tactics as their union brothers and sisters, there would be loud cries about victimisation and strong pressure placed upon employing authorities to relieve the miscreants of their responsibilities, particularly if those affected by such action were union members or their

families. Such a situation has arisen recently when a member of the medical profession had the courage to decline his services.

It is surely time that the government of this country realised two factors about those who work in hospitals. Firstly, that these people cannot continue to receive insufficient remuneration for their labours purely because they are not engaged in industry, and secondly, that a condition of employment should be that no industrial action may be undertaken by such workers. Such a policy would effectively reduce union activity in these institutions. It is true to say that most employees are not militant, but are intimidated by a small number of power seekers. It is also true however, that nurses are becoming increasingly disenchanted with the abuse to which they are continually subjected, and their tolerance is diminishing rapidly. Not for a great deal longer will they be prepared to accept responsibilities for which they are neither trained or paid. At that time, the true deficiencies of the health service will be realised.

Pam Jeffries

Physiotherapy

The post McMillan organisation of the remedial professions in the Health Service was outlined in a Report and circular whose recommendations included one asking health authorities to designate senior members as district therapists to perform largely advisory functions. In this District, we have no remedial gymnasts, so what happened was that the existing Group Superintendent O.T. and physiotherapist were respectively re-named and to mark the event, were given a small pourboire as *an earnest, presumably, of goodwill.*

During the subsequent year or so, this district organisation has evolved unspectacularly but progressively, and the report of the Co-ordinating Committee's sub-Group, on which the organisation was based, has been the subject of comment from medical and paramedical organisations and individuals.

Now the Department of Health is floating another health circular in draft, dealing this time with the management of the professions, and coming down firmly in favour of management by one's own kind, in other words of modifying the role of the district therapist from an advisory to a management one. However, it recognises that there is considerable opposition in some quarters, and that no single solution is applicable to the problems which have become evident in different situations, so flexibility is the key-note.

The circular is at pains to emphasise that the medical responsibilities for the organisation of overall rehabilitation services, and the relationship between the medical and remedial professions are unchanged, both of which had been the subject of some misunderstanding, and it accepts that in some districts, the functions of the appointed therapists have already extended to full managerial responsibility while remaining purely advisory in others.

After a period of stagnation, the remedial professions have been growing in number, and the circular comments on the increased demands which have kept pace with this growth so that overall a marked shortage remains. It points out that priority for rehabilitation services and increased numbers of remedial therapists were features of the consultative documents on priorities and planning, so that optimum deployment of scarce professional skills is of the utmost importance.

A new job-description for a manager district therapist is attached, and the point is made that, since no such creature officially exists, it will be necessary for the P and T "A" Whitley Council to agree pay and conditions of service before any appointments can be made, but eventually these new posts will be advertised.

The Department believes that this will not divert staff from clinical to administrative work, and has no intention of founding a new hierarchial admin structure. The belief that already many senior therapists play a largely organisational role is very largely true and it is probable that there will be little or no reduction in the number of therapists actually engaged in patient-treatment.

Ronald Cooper

Book Reviews

"Atlas of Medical Anatomy", by Martin W. Woerdeman and Jan Langman. Pp. x + 523, with about 1,000 illustrations. Price £15.00. Published by Saunders.

This handsome and durable volume is excellent value. The printing, reproduction, and quality of paper are all of high quality. At least six artists are responsible for the illustrations, except for a small number of photographs. Their quality is rather variable, and some of the diagrams can only be described as amateur. Nevertheless, they serve well, and cover much ground—perhaps rather too much in view of the adjective "Medical" in the title. This would be better changed to "Human", for the selection of mateiral is much what one expects and finds in any such atlas. Rather more serious criticisms are, firstly, many of the illustrations are too small and a great amount of wasted paper surrounds some of them, which could hence have been much larger; secondly far too much comment is attached and this occupies at least a third of the available space. An atlas should teach as far as possible through the medium of its pictures, with the minimum of explanation. One must assume that other books will be used with an atlas. The textual overlap is hence regrettable. Nevertheless, this is a book which will suit many undergraduate and postgraduate students of medicine and—it must be said again—it is very good value.

ROGER WARWICK.
Professor, Dept. of Anatomy.

"Controversy in Psychiatry", Eds. J. P. Brady and H. K. H. Brodie. Pp. 1087. Price £21.00. Published by Saunders, 1978.

This is an unusual book; not in its mass, or price, substantial though these are. Nor in its multiple contributorship, for this is commonly found in new books of today. The unusual feature is that each of the 26 chapters (excepting a chapter on maintenance drug therapy in depression, where one set of authors say it all) includes contributions from two or three differing viewpoints, plus editorial comment. Some of the chapters deal with issues of politics, ideology and opinion where this format succeeds. The contributions on the medical future of psychiatry (ch. 1) and the medical knowledge required of the psychiatrist (ch. 2) are excellent, with American foci which are not irrelevant to British concerns. A chapter (23) on involuntary

hospitalisation could have been equally interesting but unhappily includes a typically non-sensical contribution from Szasz. Other ideological chapters touch on the future of psychoanalysis (9) and "should homosexuals adopt children" (19).

There is something of a round-pegs-and-square-holes feeling about other chapters which ought to be scientific but are treated as if they were controversial matters of ideology. Psychosurgery (ch. 3), drugs in schizophrenia (ch. 5) behaviour therapy in anorexia nervosa (ch. 15) are examples of issues susceptible to clinical judgement. However, many make excellent reading.

This is a very good browsing book. Any topic which catches the eye on the title page is worth reading here; and some chapters (such as drug therapy in depression, ch. 7) include excellent examination-style summaries of knowledge.

J. P. WATSON.
Professor, Dept. Psychiatry.

"Immunology II" by J. A. Bellanti. Pp. 813. Price £11.50. Published by Saunders 1978.

This book takes the whole field of immunology, and starting from a historical introduction, travels through the whole of the physiology and pathology and finishes with schedules for the investigation of patients with immunological disease. Its aim is to give an integrated and sometimes philosophical view of the subject.

The text is very readable—I missed London Bridge on the underground through total immersion! There are an enormous number of diagrams clearly illustrating essential points of the text, also the many reproductions of historical photographs and paintings bring this aspect to life. The amount of illustration is probably excessive, several diagrams cover much space and convey little information. One shows glaring inaccuracy, the lymphoreticular system of a female nude included the bladder, but not the liver or bone marrow.

The book contains over 800 pages, but despite this length, the restriction of text through space for illustration has led to inadequacies. This is most severe in the clinical section, where the important topic of rheumatoid arthritis is dismissed in one and a half pages of text, one clinical illustration and an historical cartoon. Similarly, the problem orientated flow charts on the clinical investigation of immunological disease are too brief to be useful. On the other hand, with adequate treatment, the account of the pharmacology of immediate hypersensitivity is excellent, the mysteries of intracellular cyclic AMP and GMP are revealed in a memorable fashion. The same topic, however, appears in another section—with waste of space.

Immunobiology is generally covered well, again with the excellent diagrams aiding greatly. These illustrate the anatomy of the lymphoid system clearly, in contrast to many other works. It seemed difficult to use as a course of reference, attempts to look up the primary and secondary immune response showed that nowhere were they concisely described.

The philosophical tone, integrated approach and lavish illustration make this book more of a literary work than a notebook. It is too wide in its coverage and insufficiently up to date to be useful to the research worker, and its style is not ideal as a source of reference. Clearly it is too large a book for the average student to read as an introduction to immunology. Nevertheless it can be recommended to anyone with a little time who would like to get a more detailed idea of the subject and is a pleasant means of revision for those in this field. The standard of production easily justifies the price.

ROBIN POSTON.
Lecturer, Dept. Pathology.

"External Ocular Tumours", by K. Bech and O. A. Jenson. Pp. 64. Price £14.00. Published by Saunders.

This is a brief account of 300 consecutive patients presenting with tumours around the eye intended for ophthalmologists and possibly dermatologists. The clinical diagnoses and histological diagnoses are analysed. Some short notes on follow-up are included. The atlas section begins with four pages of colour photographs of clinical appearances and histology. Unfortunately some of the latter are unclear. The remaining 34 pages of photographs are in black and white only. In this section the histology is sharply reproduced.

I was not impressed by this book which relies upon a small experience, and which has a small factual content. The main message seems to be that many of the lesions which occur around the eye are difficult to diagnose clinically, and therefore, histological examination is essential in all cases. I would have assumed that this would be normal clinical practice in 1979.

DAVID TURNER.
Reader, Dept. Pathology.

"Manual of Emergency Pediatrics", Edited by Robert M. Reece. Pp. 721. Price £10.75. 2nd Edition. Published by Saunders.

Children's emergency departments serving inner city areas find themselves—intentionally or not—dealing with a wide range of pediatric disorders. Much of their work is concerned with primary medical care, rather than trauma and acute medical emergencies. The experience of the Boston City Hospital from which most of the authors of this book are drawn is similar in this respect to ours at Guy's. As Dr. Joel Alpert writes in the foreword, "in the hospital emergency setting most children who are seen have non-emergency conditions". This poses a considerable problem for the editor of a book on this subject, which can easily become an abbreviated textbook of paediatrics. The strategy followed here is to divide the material into four sections. "True emergencies"—urgent and life threatening conditions—occupy nearly half the book. "Presenting complaints" includes problems like ataxia, headache and limp. "Diagnostic entities" and "Procedures" are dealt with in the third and fourth sections.

The book does not totally avoid the temptation to be a textbook of general paediatrics—it is too large for the pocket, and in places it gives too much attention to diagnostic rarities or items which are not strictly necessary for the casualty officer, like the 32 pages on parasitology.

However, what the casualty officer mainly wants is straight-forward practical advice on what to do NOW, and in many sections this book provides it. Most life threatening emergencies are succinctly covered. The three pages on "Death of a child in the emergency department" are a superb example of clear, direct advice e.g. "No apologies should be made for the death of the child".

I was a little surprised not to see more mention of the psychosocial problems which permeate most emergency paediatrics in an inner city area. I am also unsure why the book is bound on flexible plastic rings—perhaps it is intended that the purchaser can remove the pages he does (or doesn't) like.

In summary, a useful book on a subject which is not easily covered well.

Professor R. J. ROBINSON,
Dept. Paediatrics.

"Anatomy of Students of Dentistry", by J. H. Scott and A. D. Dixon. Pp. 507. Price, £9.00 or £14.00 Cased. Published by Churchill Livingstone.

Earlier editions of this book will be familiar to many past dental students. The latest edition is considerably expanded. The print used in the book is very small giving a rather forbidding impression when reading it. However the text is broken up by plenty of diagrams and photographs most of which are good and helpful in visualising the anatomy.

The book is very comprehensive with sections on histology (including some electron microscopy), embryology, neurology and clinical anatomy. There is a large section devoted to the anatomy of the thorax and abdomen, the latter being covered in too much detail for the dental student. As it would be expected the major part of the book is concerned with head, neck and oral anatomy approached from both a regional and systematic point of view. The detail in these sections is almost too much for the undergraduate and would be enough for primary fellowship.

This book can certainly be recommended for the keen undergraduate and for the post-graduate. It has the great advantage that all the different facets of anatomy—ranging from histology and embryology to topographical anatomy—are found between the covers of a single book, this of course excludes any special dental anatomy.

M. C. E. HUTCHINSON,
Lecturer, Dept. Anatomy.

"Ambulatory Care Systems. Volume III. Evaluation of out-patient facilities", by Paula L. Stamps. Pp. 251. Price £14.00. Published by Lexington.

This volume on evaluation of out-patient facilities is one of a series of five on ambulatory care systems which bring together six years of research by an interdisciplinary team at the University of Massachusetts.

The Chapters cover evaluation of ambulatory care; patient, and provider, satisfaction; medical audit and applications of industrial quality control systems.

The title is attractive because there is a need to encourage out-patient care wherever suitable in view of the increasing costs of a decreasing number of beds.

This book deals in a comprehensive manner with methods of evaluation at present in use and includes interesting descriptions of eight approaches to medical audit.

Organised evaluation is evidently an extensive process and reading about it here gives an alien feeling to out-patient departments where patients, doctors, nurses and receptionists serve as raw material for study.

These business efficiency evaluations of medical care are valuable but cannot stand alone. They need human sympathy in their application because goodwill is a vital element which is easily lost although the effect of its loss may be slow is becoming apparent.

Major-General ROGERS,
Clinical Superintendent.

"Emergency Medical Systems Analysis", Ed. by Thomas R. Willmain and Richard C. Larson. Pp. 177. Price £12.05. Published by Lexington.

The resistance of the citizen as taxpayer to paying for the increasing costs of medical care is leading to more studies of "cost-effectiveness" and this means finding acceptable criteria for assessing "effectiveness". A team was brought together at the Massachusetts Institute of Technology to study "Urban Emergency Medical Services in the U.S.A." and this book reports its findings and proposals.

The studies examine emergency care situations in cities, covering attitudes of patients, bystanders and emergency staff as well as arrangements for screening calls for ambulances and their location. There are chapters devoted to construction of models of the hospital emergency medical department and of emergency treatment of myocardial infarction. The team contained operations researchers, urban planners, engineers, sociologists, urban historians, mathematicians and one doctor.

The resulting text is not easy reading for an ordinary doctor yet it is of absorbing interest and points a way towards evaluation of methods of care and use of resources which could assist institutions and services in making balanced decisions about policy when need is often not fully represented by the narrow claims of pressure groups.

Dr. Willemain, who is one of the editors, writes: "Unfortunately, mathematical models are most alien to physicians who rarely speak mathematics.... In the course of our research, we have met and worked with physicians who are adept at conceptualising clinical models but they remain a rare breed."

Many of us are stumbling about amid plans and planning figures, often doubting their accuracy and disputing inferences to be drawn from them.

We need the help of the rare breed especially those from the ranks of practising doctors.

Major General ROGERS,
Clinical Superintendent.

Correspondence

Accountability in the N.H.S.

Sir,

Mr. Konzon's comments on my article "Surgery—too little; Science—too much" could not have come at a more unfortunate time for him in his endeavour to minimise the difficulties in the N.H.S. Does he really think that District Management Teams which currently cower under the threats of the NUPE and COHSE are an effective instrument of management? Does he find himself steeped in idealistic dogma to an extent where he feels that the deprived and the dying are not worthy causes for the reassertion of professional responsibilities?

His ludicrous comment about my House Surgeon's alleged failure to give full explanation to the patient is the product of ignorance. Does he really imagine that visible haemorrhage requires a lengthy explanation to the patient before someone does something to stop it? Of course my House Surgeon explained the situation fully. If the patient had any grounds for complaint he could and should have come to me rather than involve the C.H.C. whose understanding of the matter was totally inadequate.

From the contents of his final paragraph I imagine Mr. Konzon has not yet grasped the fundamental realism that in medicine the accountability of the clinician is to his own pride in professional standards and that this, the most important yardstick, is the one from which the patient is likely to get maximum benefit. I hope it will be possible for some of his teachers to

inculcate this feeling in him before he completes his education.

Yours faithfully,

FRANK ELLIS, M.S., F.R.C.S.,
Consultant Surgeon, Guy's Hospital.

97 Harley Street,
London, W1N 1DF.

The War Memorial Arch

Sir,

I should like to support the plea made by Dr. Mann and Dr. Erskine for the re-erection of the War Memorial Arch at Guy's.

Dr. Mann is quite correct in his assumption that the Governors of the Hospital were appointed trustees to maintain the Arch in perpetuity. This was established by the late Sir Rowan Boland before the dissolution of the Board, and presumably, the Lambeth, Southwark and Lewisham A.H.A. (T.), as the Statutory Authority which took over from the Board must have inherited the obligation.

When Sir Rowan Boland raised the issue, it was shelved on the grounds that a final site could not be determined until the plans for Phase III of the rebuilding had been agreed. It would require a great deal of optimism to believe that the chances of Phase III being completed within the forseeable future are remotely possible and, therefore, the objection no longer applies.

It may be that the argument will be raised that at a time of such extreme shortage of resources it would be wrong to spend money on a project which clearly is of little direct benefit to patients. I have held the view for a long time that the Health Service cannot survive in its present form if it continues to depend entirely on central Treasury funding for its resources. I should, therefore, be very pleased indeed to contribute to a fund started for the purpose of restoring the Arch.

It is some years now since I looked at the dismantled pieces where they are "dumped" at St. Olave's Hospital and their condition then was not very encouraging. I think that as a matter of some urgency an estimate should be obtained of the cost of restoration and then at least we should know where we stand. Simply to ignore the situation is legally indefensible and morally irresponsible.

PHILIP J. HELLIWELL.

"Brettes",
Monks Eleigh,
Suffolk.

The War Memorial Arch

Sir,

I have just read in the January *Gazette* the letter of David Erskine concerning the War Memorial Arch and I am in complete agreement with his sentiments.

His letter omits to state that the names of those lost in the 1939–1945 war were also carved on this gate, in fact on the Park side of the gate, the side shown in the photograph in the December *Gazette*, and I think that in the photograph that there is a suggestion of these inscriptions.

I remember seeing on this side of the gate, low on the right hand side, the names of my brother F. H. Weston who was lost on the Rawalpindi, and the name of my cousin "Billie" F. G. Weston who was killed by the Japs in Singapore.

Each Remembrance Day we say or we think, "Their Name Liveth For Evermore", and so it does to those of us who knew them, but if this Memorial were erected, as Mr. Erskine suggests, in some suitable place in the Hospital grounds, then future generations might note the names of these young men and some not so young who gave their lives in a struggle against tyranny.

I am Sir,

Yours sincerely,

GEORGE WESTON,
Guy's [1921–1928]

115 Parkanaur Avenue,
Thorpe Bay,
Essex.

Radio Guy's

Sir,

Radio Guy's originally started broadcasting to the patients of Guy's Hospital in March 1969, with all programmes being recorded in private studios. In April 1971 the station moved into Hospital premises at 15 St. Thomas Street, from where programmes were broadcast live to the patients.

Programme output expanded both in duration and content, until June 1977, when due to the Hospital Authority's wish to redevelop the St. Thomas Street site, the station closed down pending the establishment of new studios in a different location.

Since June 1977, the members of Radio Guy's have continued to plan programming and the station's name has been kept alive in the Hospital by way of the annual Guy's Hospital Nursing Personality of the Year Contest, organised and presented by Radio Guy's.

During the past year new studios have been constructed in an area previously housing a diet kitchen. Since structural completion in October 1978, Radio Guy's engineers have been installing broadcast equipment in the two sound studios and master control room.

On Tuesday 6th March 1979, Radio Guy's will officially re-open, almost ten years to the day of the original opening. Broadcaster David Jacobs will be present to declare the station re-open, on air. Additionally, many Hospital dignitaries, as well as representatives from the Hospital Trust Fund who paid for the studio construction, will be attending. Many radio and television stations from the South of England have sent special "good luck" tapes, and these will be broadcast during special programmes on the evening.

Yours faithfully,
MIKE SMITH.

Radio Guy's, Guy's Hospital,
St. Thomas Street, SE1 9RT.

Where is the Support?

Sir,

Recently several letters have appeared in the *Gazette* concerning the state of sport at Guy's and the general apathetic attitude that seems prevalent at the moment.

As officials in the various clubs and societies within the hospital we wholeheartedly agree with these sentiments and would like to take the matter further.

We believe that the spirit of any community depends on those who are part of it taking an active interest in activities outside their daily work. It is our belief that this isn't happening at Guy's.

Part of the blame for this must fall on the students shoulders but equally so the people who select and govern the students are at fault. Surely they must realize that doctors and dentists must be able to communicate with people and that the best way to achieve this is to mix with as many different people with a varied selection of interests as possible. However this does not seem to be encouraged here.

One way in which the authorities could assist is to allow, or better still encourage students to take Wednesday afternoons off to pursue some different activity.

We would welcome the views of any Guy's men or women on the state of affairs at the moment.

Yours faithfully,
D. HETT, G. PARRY, A. G. PIGOT,
D. RICHARD, V. TUN, S. PERKINS,
G. PALMER.

c/o Boland House, SE1 9RT.

The Churn

Sir,

Ref. a footnote to your article re. the Churn.

The "Churn" "was sneaked" by **R. Curle.** N. S. H. Warner and A. C. Hancock had nothing to do with it.

I was present and saw the whole incident.

Yours faithfully,
HORACE MATHER.

Westend Lodge,
Waddington,
Clitheroe.

The Hospitals' Cup

Sir,

On the 16th January I watched Guy's Hospital Rugby Club play against Charing Cross Hospital in the first round of the Hospitals Cup and I was appalled at the lack of support. It is somewhat discouraging for a team when less than a dozen people turn out to support and our opponents have between 200–250 of their students and staff to cheer them on. Is it too much to expect a similar pride in our hospital as others seem to have in theirs? At Charing Cross lectures were cancelled or rearranged so that time was made available for any who wanted to support, and people were encouraged to go. Here, however, we get no encouragement and sadly there appears to be a trend towards apathy throughout the various clubs of the union. Are the students so much different at Guy's? I think not. So where does the blame for this trend lie?

I am sure that our predecessors would be disgusted with the way people behave now in regard to their pride towards the hospital. Within the Rugby Club we were viewed at Guy's with envy at being members of Guy's and the oldest Rugby Club in the world. Now we have to put up with contemptuous comments from clubs we once swept aside. It seems sad that the name of this hospital should be treated in such a manner.

Of those who did support at Teddington I offer the thanks of the Rugby Club and especially to Eric and Joyce Dann who came along to give their support and encouragement. Perhaps, it is too much to hope that people will turn out to support us in future.

Yours faithfully,
ANDREW STRACHAN,
Junior Team Secretary,
Guy's Hospital Rugby Club.

Flat 7,
57 Crystal Palace Road,
East Dulwich.

The Medical Directory

Sir,

Your plea in *News in Brief* in January for a start on Guy's Medical Directory, prompts me to write and give you my support, as I have thought many times what a pity no one will volunteer to organise it. As one grows older one appreciates ever more news of colleagues one would otherwise lose sight of!

What work will be expected of volunteers? Is it to collate up-to-date news of everyone? Is any register kept at Guy's of deceased, additions, and changes?

If it does not involve me in funding the postage to everyone on Register and Directory, I would seriously consider offering my services to organise up to date editions. Your views and comments please.

Yours sincerely,

Dr. A. H. DREWITT.

Sands House,
3 Oakwell Avenue,
Bridlington,
North Humberside.

Salad Days

Sir,

My heart fell as I entered the Greenwood Theatre to find in place of the twenty piece orchestra, just a couple of pianos, an electric bass and drums. My eyes moistened as I remembered those halcyon days of the Guy's arrangement of the National Anthem, the shaky sight reading of the only first violin, and the well lubricated brass section, totally obliterating any finesse the neglected conductor was trying to introduce into the proceedings, as he strove to match the tempo of the orchestra to the tempo of his singers. Instead, we were immediately launched into the overture, punchily played by the combined pianistic talents of Richard Groves and Mike Lavell, the electric bass of Mark Longden, and the percussive tendencies of Dick Mallet, and within twenty seconds the ghost of the Guy's orchestra had been laid.

This production of Salad Days was in some ways ambitious requiring a plethora of players, many of whom assumed more than one character. But, the main difficulty in performing this work lies in the brevity of some of the scenes. Gilbert and Sullivan productions have long acts in which failure to establish characters immediately may be redeemed in the passage of the act. Such a failure in Salad Days means that a complete scene doesn't come off, despite the best endeavours of players in other scenes. Fortunately, such disasters failed to occur in Adam Searle's witty production and every scene contributed to the success of the evening.

It is customary to comment on all who had name parts, but with over thirty of them, it must suffice to mention a few. The efforts of Adam Searle, acting, choreographing and producing, were unequalled, and his portrayal of Timothy was the dominating force of the show. Peter Saunders, playing several different parts, excelled as Sir Clamsby Williams, an obsessively secretive civil servant, with Chris Allen embarrassingly good at playing his witless sidekick Fosdyke. Though she lacks experience, Margaret Foxton showed promise, and Clare Allen was splendidly nauseating as the social climbing Fiona. Juliet Dowler, the salesgirl Rowena, and Vincent Barratt, as P.C. Boot, together provided some of the best laughs of the evening. Alan Watson "starred" as the effete couturier Ambrose beset by disaster after Juliet Dowler and Kay Worell, abandoning her sinecure as a don, descended the social ladder during the show, to find her true vocation as a sleazy night club singer, a decision that I heartily endorse.

The show provided a chance for everyone to star, and all so availed themselves of the opportunity that one forgot that there were only five people who had previous experience as principals with the society. With the wealth of experience gained from this show, the next production should achieve great success.

ADAM SKINNER.

c/o Boland House, SE1 9RT.

Getting Here

Sir,

Having worked at Guy's in the Staff Health Service for 28 years I have come to know a large number of staff and students in all departments of the Hospital. With few exceptions they are highly conscientious and it has caused a great deal of depression and despondency to receive such an unhelpful circular of instructions about getting to Guy's during the recent strikes. Staff appear to have been told they must either get here or take the days on which they cannot do so as holiday, or not get paid, but this latter instruction has not been put in writing.

Little help or encouragement has been given to the staff; they have merely been

asked to give other staff lifts if possible, but no extra parking space has been arranged, and should they incur extra expense in an effort to get to work it will not be refunded. I am told by a relative on a Hospital Board that to stop the pay of monthly salaried staff in these circumstances is illegal.

I do not think it is generally realised that some senior and some junior staff have even brought in camp beds and sleeping bags and have slept in their offices in their determination to be at Guy's "come hell or high water".

Would it not have been much better to send round a helpful notice saying that it was realised that all staff and students would make every effort to get to work, and to have given a few positive suggestions on how to get help to do this? When one reads of all the extra effort put in by employers and help given to the staffs of banks and offices it is very disheartening to receive the type of notice which was circulated.

I do not think it is appreciated what a vast amount of overtime is put in by the staff for which payment is never claimed (in fact the secretarial staff have been told that they are no longer allowed to claim overtime). Is it not time that the staff received a little more appreciation and encouragement, especially when life is as difficult for them as it is at the moment? I personally have had no travelling problems to date, and therefore have no axe to grind.

Yours faithfully,

MARY VICKERS.

Staff Health Service,
Guy's Hospital, S.E.1.

The Dwindling of First MB and First BDS

Sir,

We welcome the support for the Preliminary Year Course at Guy's—the old First MB and First BDS—which was expressed in *Passim* in a recent issue.

We would like, however, to correct some of the figures given in that article. In London, Guy's offers 40 places each year, 20 for Medicine and 20 for Dentistry; and the table below gives the numbers of applicants and admissions during recent years.

Bart's offers 28 places, 14 for Medicine and 14 for Dentistry; and this year's course has 27 students (14 in Medicine and 13 in Dentistry).

It is also of interest that Southampton University Medical School has just started up a Preliminary Year Course.

Yours faithfully,

E. W. BAXTER,
Department of Biology.

S. J. WYARD,
Department of Physics.

Guy's Hospital Medical School,
SE1 9RT.

Sir,

With reference to the *Passim* on the "Dwindling of the 1st M.B./1st B.D.S." I would like to apologise for any inaccuracy which may have been implied by the figures quoted.

The estimates were taken from the G.M.C. reports on Basic Medical Education published in 1977. I have recently received a letter from the Dean of Barts who "estimates" that approximately 30 students are currently on the preliminary course, 15 medics and 15 dentists (linked to the Royal Dental Hospital).

Professor Wyard has supplied recent figures for the number of admissions and applicants to Guy's Hospital. I would like to add that Manchester Medical School has recently reviewed the preliminary year, to integrate more with the Preclinical course. They presently have 10 students but are keen to expand the course dependant upon sufficient demand from schools and graduates.

Yours sincerely,

R. TREMBATH.

c/o Boland House,
Guy's Hospital,
SE1 9RT.

The Guy's Dry Fly Fishing Club

Sir,

"A thorough disgrace to British hospital medicine—as far as I am concerned the G.D.F.F.C. is finished." Such were the words, not of some Bart's scrubber or back street fishmonger, but of Lady Jane Finsley herself—one of the G.D.F.F.C.'s most faithful and generous supporters. She was heard to utter these words after the disastrous match against the Cook-

Year	1971	1972	1973	1974	1975	1976	1977	1978
Applicants for Medicine	291	395	349	168	205	297	267	207
Admissions	12	16	16	19	16	16	19	13
Applicants for Dentistry	74	75	118	172	130	109	106	63
Admissions	26	22	23	15	14	15	4	4

ham Nobblers Angling team last Saturday, and her words rang true. For, at 5.30 p.m. on that day a red-eyed and dejected Sir Adrian Weston stood to address the gathered company, including his team mates Dick Reading and Chris Parker, and announced the closure of the G.D.F.F.C. And so ended the life of a club that had only lasted 174 days, and which was due to celebrate its half yearly birthday next Saturday. Indeed, Sir Adrian's tenure of office is believed to have been one of the shortest in Guy's clubland history.

It would be unkind to all concerned to analyse too closely the events of that fateful day. The day started off well for the Guy's men, who were once again casting with the wind. Indeed, at lunch time they looked all set to romp home to victory with an incredible six grayling to the opposition's none, and with two members of the opposition team having been sent off for using worms. It was when the police arrived at 2.00 p.m. to confiscate the team's tackle for fishing out of season that all hell was let loose, and the shock hour began. Sir Adrian shouted at the unfortunate Dick Reading for not warning him about the closed season dates. Dick Reading replied that if Sir Adrian was all that he cut himself up to be, he should have known the dates anyway. Lady Jane Finsley interjected at this point and asked crossly why everyone always blamed "her" Dick, and told Sir Adrian and Chris Parker that they ought to resign from the club. At this juncture, Chris, discarding his famous English phlegm, called Lady Jane a slag, told her that he found her rather common, and that she didn't have any say in the matter anyway. This remark was met by clods of earth kicked by the ever chivalrous Sir Adrian and Dick at Chris's face. The damage, however, was done. Lady Jane left announcing that if she was a slag, she might as well go and enjoy it, and the entire team was booked.

It is, perhaps, far too early to assess what will have been the historical significance of the G.D.F.F.C. in contemporary medicine. Indeed one can only speculate as to where the blame for its premature liquidation should lie. Some of it must inevitably lie on the shoulders of Dick Reading for his entirely fatal attraction to Lady Jane; a latterday Lolita trying to play Cleopatra. Some must also be due to Chris Parker for his insistence on sticking to the rule book, and his old pre-match parties. But what of the man on the tiller himself. Only history will be able to decide whether Sir Adrian Weston was a Nelson without the Nelsonian luck, a Nelson without the Nelsonian touch or simply an incompetent megalomaniac, who was never to be trusted with even a couple of damp kippers.

To some the G.D.F.F.C. was just a cliché in bad taste. To these people its only importance will have been the introduction of a few new phrases such as "Upper Class Tint", "Didn't he cast well?" and "Give me back my Greenwell's Glory you Cod Parker". To others the G.D.F.F.C. was an important new concept, whose eclipse was itself symbolic of a sick society that is over-obsessed with social change and clear thinking at the expense of social graces and simple old fashioned decadence.

To such people, the wonder of it all will not be the rapid demise of the G.D.F.F.C. but the sheer fact that in 1978 it was ever able to exist at all in the first place. We should, perhaps, consider Messrs. Weston, Reading and Parker not as Rudolf Hesses but more as Scotts of the Antarctic. That is to say Failures, but failures, whom history will remember long after any number of heroes have gone home to roost. And so, men of destiny or simply fools? We shall probably never really know.

M. D.

Sport

SPORTS REPORT

It's nice to be back in England after my two month stay in America. Next month my good friend Brian Bore has promised an exposé on American sport. Many thanks to Gary Calver—sports editor stand-in last month and hopefully your sports editor of the future (as soon as possible say you!) It hadn't occurred to me that there could be anyone at Guy's who specifically dislikes sport of all kinds as Gary has suggested. If such people exist they must live under stones and eat seaweed, never appearing in daylight. It seems this person could not exist at Guy's. It worries me more that there is a huge mass of people who like

sport in small doses when they feel like it. If it is cold or inconvenient they make an excuse not to play. A fabled soccer star became so apathetic one season that he made the excuse he was going to a wedding on Saturday seven times in one season. By the end he had forgotten who he had married off in his family and who was still single. Another present vice-captain used to go to the dentist in Stoke more than his parents could possibly afford. It is fair weather sportsmen and women who must be encouraged and chivvied into giving more to their teams. One way of promoting sport at Guy's would be for all present sportsmen to try and persuade their friends to support their teams. If they did H.O.P. would become a much more sociable place on a Saturday. I hope Gary Calver may make some more suggestions in the future. He may be thinking of writing a "Joys of Sport" book to rival Alex Comfort's bestseller. Anyway I hope his right arm is never still, as he suggests (whatever that means).

Another sad thing to have happened whilst I was away was the demise of the Dry Fly Fishing Club. This enigmatic society came to a dramatic end in a way I can relate further to M.D.'s obituary (see Pissim). Apparently, after "Red" Reading's marriage to Lord Finsbury's daughter Jane and his accession to the title after Lord Finsbury's awful and mysterious death a week later, former club captain Sir Adrian Weston besmirched the reputation of Lady Jane in a none too distinguished Sunday paper. Following an ugly brawl in Sir Adrian's London Club, the new Lord "Red" Finsbury withdrew his financial support, his stretch of river from the club and broke all it's fishing rods. So unfortunately due to lack of funds this old club has been forced to close. I hope one day someone rich enough will be able to revive it.

There has been very little sport indeed at Guy's in the last month. What matches that have been played took place in freezing winds, rain and hail. I hope the weather is going to pick up enough to enable fixture lists to be completed as many promotion or relegation places are at stake. Good luck to the Soccer 2nd XI in their quest for the Hospitals' reserve cup and if you can possibly get out, try to go and support at least one of YOUR hospital's teams this month. Come on, shake off your apathy and let's make Guy's proud of it's sporting teams!

JONOTHAN EARNSHAW.

RUGBY

Guy's Past 3 pts. Guy's Present 6 pts. Sunday, 4th February, 1979

The Present side turned out rather fresher than usual after cancellation of their fixture against Coventry on the Saturday. This was fortunate as John Davis had organised a strong experienced side for the Past and a closely fought battle ensued. The Past took the lead with a penalty kick from Liam Hughes in the first half, another penalty hit the post, and bounced back into play. The only try of the game went to the Present —appropriately scored by Terry Gibson who has organised the weekend's festivities. The conversion by Graham Francis gave the Present a winning lead although Hughes missed another good chance to level the scores with another penalty late in the game.

The evening continued with excellent food and company, emulating the success of the previous evening's dinner and dance, and Eric and Joyce at Honor Oak Park are once again to be congratulated. One should note for next year Alistair Cooke will take over the role of organiser for the Past from John Davies who has done some great work for the first seven years of the fixture. Many thanks to all who supported the weekend, one of the highlights of the Rugby Club's season.

GUY'S 6 pts. GUILDFORD 16 pts. Saturday, 10th February, 1979

Guildford brought a strong side to Honor Oak Park including Liam Hughes an ex Guy's captain, but playing with the wind in the first half Guy's took a six point lead, through a penalty and a drop-goal by the steadily improving outside-half Mike Hackett. The Guy's pack were well on top in the scrums and loose play but struggled in the lineout. However in the second half this lead was shown to be too narrow as Guildford got back into the match with two penalties and a converted try. The Guy's scrum continued to do well with several heels against the head in important defensive positions. It was good to see the strong second row man Jeremy Gray back in harness as well as Mike Broughton and Graham Francis safely back from Tanzania. The backs looked awkward at times in attack and defence but with just a bit more effort to train regularly should mould into an effective unit.

Gary Manning has especially benefited from a run in the first team, playing a very solid game at full-back.

Guy's: Parry, Gibson, Neill, Gray, Keevil, Brazier, Flanagan, Girling, Laws, Hackett, Broughton, Wilkinson, Portelly, Francis, Manning.

G. P.

Back Row: R. Howgill (Referee), L. Hughes, C. Lewis, D. Stuart, R. Burt, K. Rigg, S. Kennedy, I. Neill, B. Keevil, C. Robertson, A. Campbell, T. Wilkinson, G. Manning.

Centre Row: J. Davies, M. Danford, C. Thorburn, T. Gibson, A. Girling, G. Parry, R. Moore, C. McLaughlan, R. Yetton, T. Higgenbottom, J. Brazier.

Front Row: M. Broughton, A. Cooke, T. Portelly, R. Flanagan, H. Williams, G. Francis, R. Laws.

Missing are Swift—the Past scrum-half, still lacing up his boots and Mike Portelly who is taking the picture.

SOCCER

2nd XI Mid-Season Report

Another season has passed the halfway mark and yet again (DC) Guy's Hospital 2nd XI are in a comfortable league position and within reach of the Hospital Cup Final.

After an excellent start to the season Guy's found themselves sitting at the top of Division 2 of the U.L.U. league with high hopes of promotion. Indifferent form since this time has seen the side slip to a mid-table position but one which can be improved upon in the remaining games.

In the Hospitals Cup the side has high hopes of reaching the final for the third consecutive season. Charing Cross provide the opposition in the semi-final this year and after one meeting which did not provide a winner (see report below) Guy's must be confident of reaching the final.

Hospital Reserve Cup—Semi Final
Charing Cross 3, Guy's 3
(after extra-time)

This match was the most exciting game played by the 2nd XI this season.

The match began in drizzle which did not seem to dampen the spirits of any of the players or the magnificent Guy's Kop (Liam "Jim-lad" Broughton

and Martin "Manuel" Davies) to whom many thanks.

Guy's had the edge for the first quarter with the team giving nothing away and taking the game to Charing Cross. After 20 minutes John Rawcliffe picked up the ball on the edge of the opponents area and hammered the ball into the top left corner to open the scoring.

On the half hour the Hyde character of Guy's 2nd XI suddenly appeared yet again for the remainder of the first half and for the first 15 minutes of the second the team became spectators and allowed Charing Cross to run the game and take the lead with two scrappy goals.

As if operated by a switch the team seemed to return to top gear at the realisation that they were now trailing. Constant pressure was finally rewarded when Jon Earnshaw was sent away and Keith Underwood rammed home the rebound after the original shot had been parried.

The final whistle blew and tired limbs grew heavier at the thought of extra-time. Guy's however now showed that they were the superior side, after constant pressure, Dave Smalley took advantage of some slack defensive work to set up a simple goal for Jon Earnshaw. Everyone seemed to believe this would be enough but this lax attitude was punished only 4 minutes from time when Charing Cross equalised from a corner. So the game goes to a replay when really Guy's should have been through to the final at the first attempt.

Mention must also be made of the after proceedings with some magnificent scenes in the bar which hopefully will be repeated after the replay.

Team: N. Cowland, A. Williams, R. Trembath, D. Abrahams, M. Batterbury, R. Daines, D. Smalley, D. Greenaway, K. Underwood, J. Earnshaw, J. Rawcliffe. Sub.: M. Davies.

LADIES HOCKEY

CUP MATCH REPORT

Guy's 7, Westfield College 1

By popular request here is an unbiased match report from no less a person than the umpire. A difficult task; the match appeared rather one sided!

Starting only three hours late, nothing unusual some sources tell me (no, seriously nothing to do with Guy's), our ladies, hockey sticks and white legs flashing in the afternoon sun, quickly leapt into the lead, thanks to Cathy Irwin who seemed intent by the end of the afternoon to reach double figures.

With Kristia, Sally and Julie in command of the midfield, some dashing runs on the wing from Martine, eager to show us how well they play hockey in Belgium, it was left to Cathy to slot another four goals in before halftime (which despite claims to the contrary from certain people was half an hour after the start).

In the second half Westfield proved silghtly more troublesome and Helen, in goal, had the chance to kick the ball back from whence it came once or twice.

Another two goals for Guy's, one from Kristia (proving she can still put the ball in the net despite her pleas to the contrary), another from Cathy (who else?), and a late goal from Westfield ended the match. So congratulations to Kristia and her team for such a convincing performance and thanks to Alex for umpiring with me.

M. P. V.

MOUNTAINEERING

The mountaineering club's Dinner Meet was held once again at Cobdens Hotel, N. Wales. Inspite of a somewhat traumatic journey—M6 closed due to adverse weather conditions, while Shropshire's roads remained ungritted due to industrial disputes, we all arrived in the early hours of Saturday morning.

A luxurious night was spent in, not too warm, beds, and we awoke in high spirits to find three more inches of snow and bright sunshine. If not perfect for the motorist the weather left little for the mountaineer to desire—indeed it was even rumoured that two members were seen without their shirts on the slopes of Glyden Fach.

Muel Siabod was conquered by our party, who frequently found themselves waist deep in powder snow, and managed to cover the upper halves of their bodies equally effectively by bombarding each other with snow boulders.

Ending a fantastic day with a change of clothes, an aperitif in the bar, and a well cooked meal certainly made this years dinner meet one to remember.

JEAN PRIOR.

Guy's Hospital Gazette

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GUY'S HOSPITAL,
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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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Passim

Every five years the Medical and Dental sub-committee of the University Grants Committee visits the hospital to sound out the views of staff and students for the next five years' allocation of resources.

It is crucial that we fight our case vigorously, for the Government is intent on closing one of the London teaching hospitals. A spokesman for the University said, *It is already clear that the financial support for medical teaching in London has been so reduced that a stage may be reached when the total revenue available will be insufficient to enable all the existing medical and dental schools and postgraduate institutes to continue.* For this the University blames the Department of Health's policy of redistributing money to poorer health regions (The Resource Allocation Working Party; R.A.W.P.), but of course London trained doctors and dentists serve the whole country.

A working party under Lord Flowers, Rector of Imperial College, has been set up to examine the "extremely serious" financial position of twelve medical schools and other post graduate institutes which train nearly one third of our doctors and dentists. However, reports of working parties are notoriously often forgotten about, especially if they are contrary to official doctrine.

Heady talk about the Deans of the Schools standing in defiance of the Government might be reassuring but is as quaint as it is useless. Thankfully, these days, any Government walks a political highwire and therefore we must continue to argue the folly of "levelling" policies to those who may easily be the next Government.

Gazette Staff Appointment

This month the *Gazette* is very pleased to welcome Philip Razzell, B.Sc., to the post of Joint Editor of the journal. I know that Philip, who has been on the staff since September '77, will continue to contribute in his individual style.—A.P.

Guy's Hospital Gazette

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: 16th April and 14th May, 1979.

Copy may be sent to us at 16 St. Thomas Street, SE1 9RT.

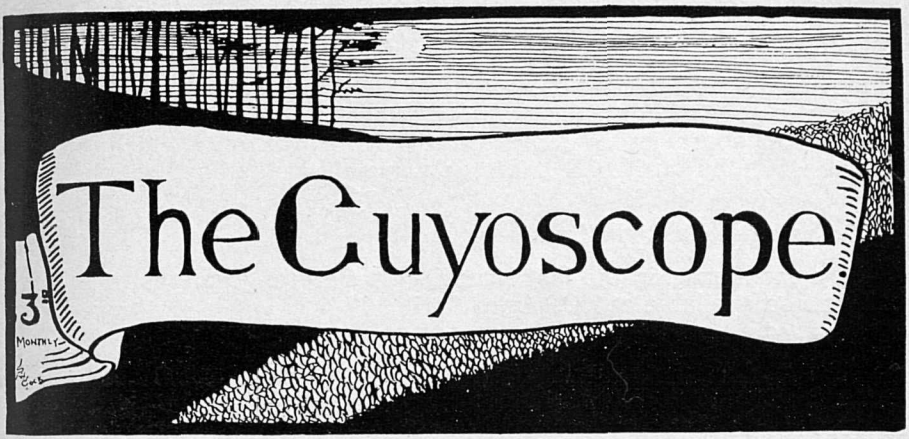
Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (prepaid, minimum £2.00).

Non-subscribers are charged £2.00 (prepaid) for all notices other than Death.

News in Brief



The *Guyoscope* listened with the accuracy of the stethoscope to the crisp crackles of wit, to the dry bubbles of fun, to the *bruit d'humour* of hospital life. In its brief run at the turn of the century it was the *Punch* of the medical world.

The *Daily Telegraph* wrote "After a brilliant existence of ten months the genial little periodical which bore the title of the *Guyoscope*, and was the organ of the great hospital near the Surrey end of London Bridge, has come to an untimely end. It died through too much medicine".

Learn more of the *Guyoscope*.

Visit the exhibition in the Dental Library, Floor 27, Guy's Tower.

Open until April 30th.

Naval Promotion for Guy's Dental Surgeon

Our heartiest congratulations go to Surgeon Commander (D) H. K. Kemp, RD, BDS, FDS, RCS, RNR, who has recently been promoted to Surgeon Captain (D) RNR, and as such is now the Senior Dental Surgeon in the Royal Naval Reserve. Surgeon Captain Kemp, who was born in Frome, Somerset, qualified from Guy's in 1957 and was a prizeman in Medicine and Surgery and also won a full blue for shooting. He joined London Division Royal Naval Reserve on completion of a three year short service commission in the Royal Navy which included eighteen months on H.M.S. *Victorious*, mainly in the Far East.

Guy's Hospital Basketball Club

As mentioned in the last issue of the *Gazette*, facilities for basketball will be available at HOP from April.

So why not start a summer basketball team?

Players of all standards and heights welcome. Please contact Jerry Hackett or Uli Pffifer via Boland House pigeon holes or the bar as soon as possible so that regular coaching sessions can be organised.

Royal Academy of Arts

Vouchers for admission to the Royal Academy's Summer Exhibition at a reduced price of 50p are available *free at* the *Gazette* office. The exhibition runs from 19th May to 12th August, 1979.

About this month's cover

Our cover shows the Church of St. Thomas' (now the Chapter House) which stood by the entrance to Old St. Thomas' Hospital. The building is now a fascinating museum incorporating an old operating theatre and displays of instruments and contemporary pictures. It stands directly opposite the present *Gazette* offices in 16 St. Thomas' Street. Colour reproductions of a watercolour by Yates (1825) showing this building from a different angle are available from our office, price 25p.

Crime in downtown Guy's

At one point last year Southwark Police found that one in four of the non traffic crimes they dealt with happened at Guy's Hospital! Outside criminals are at present taking advantage of the difficulties of policing all the buildings day and night, and thefts are now approaching 1,000 a year. Let our readers within the hospital be warned—safeguard your valuables and report suspicious occurrences to Security.

The Crumbling Chimney

Repairs to the chimney in Guy's Tower could cost up to a million pounds according to the Area Health Authority, and two official enquiries have been launched to determine the causes of this expensive mishap. If blame is determined then legal action may follow, itself a long and costly process.

Guy's Tops in Scientific Photography

Kevin Fitzpatrick, Marina Morris and Stephen Sitch, prizewinners at the I.S.T. International Photographic Competition.

At the Institute of Science Technology 1979 Annual International Photographic Competition four members of the Medical School staff won prizes. There were some 300 entries and the Competition took the form of a display at the Birmingham National Exhibiton Centre on 12th–16th March, 1979.

The winners were:—

Stephen Sitch (Junior Laboratory Scientific Officer):
1st prize in the Junior Technical Section.

Marina Morris (Junior Laboratory Scientific Officer):
1st prize in the Technical Biological Section.

Kevin Fitzpatrick, M.I.S.T., A.I.M.B.I., A.R.P.S.:
1st and 3rd prizes in the Professional Technical Section.

Derek Tremain, M.I.S.T.:
1st and 3rd prizes in the Technical Medical Section.

We offer these four our heartiest congratulations.

Beta-pathy Guy's Charities' Week

The charities' week events organised by the Guy's students gave satisfaction to both its organisers and participants, and have provided in excess of £1,000 to be distributed between various charities. It recalls the student fund-raising of pre-N.H.S. days, when the existence of the Hospital depended greatly on such voluntary contributions. Contrary to opinion at Guy's it would probably be fair to say that our students are among the least apathetic of the London Hospitals—as enterprises like *Tablet* and the Quodlibet Society bear witness. Long may it remain so.

World Record for Guy's

Mr. Michael Craig and Mr. Paul Revell attempted the world record snooker-playing marathon on Friday, 16th February at Boland House as part of the Charities' Week. Supervised by Mr. Bompas and Dr. Hutchinson for Guinness Superlatives Ltd., the two men played for 134 hours 59 minutes—a total of 253 frames—and thus hold the world record. The players were honoured by the visit of a delegation from the University Grants Committee who were visiting on the 20th. Perhaps the U.G.C. will spare our medical school the fatal axe, now that they see what Guy's Men are made of.

Dates from the Medical Diary

April

Wed. 4 Examination for the Golding Bird Medal and Prize in Obstetrics and Gynaecology begins.
Fri. 13 Good Friday. Medical School Office closed.
Mon. 16 Easter Monday. Medical School Office closed.
Fri. 20 Final M.B., B.S. (Old Regulations) Examination begins.
Mon. 23 Schedules for the Final Conjoint Examination in June must be left in the Medical School Office not later than this date.

SUMMER TERM BEGINS

May

Mon. 7 Bank Holiday. Medical School Office closed.
Mon. 21 Entries close for the Final Conjoint Examination in June.
Mon. 28 Bank Holiday. Medical School Office closed.

Guy's Hospital Dental Directory

A new edition of the Dental Directory is now available to our dental subscribers, containing up-to-date alphabetical and locality lists of Guy's practitioners.

Available from the Sub-Dean of Dental Studies, Medical School, Guy's Hospital, London, SE1 9RT.
Cost £1.25 (inc. postage within U.K.)

Cheques to be made payable to Guy's Hospital Medical School.

Applications are invited for the following Scholarships for the Session 1979–80. Forms are obtainable from the Dean and should be returned not later than 30th April, 1979.

The Beaney Scholarship in Materia Medica

Candidates for the Scholarship must have received part at least of their medical education at Guy's Hospital Medical School. The object of the Scholarship is to advance knowledge of Materia Medica (including Pharmacy, Pharmacology and Therapeutics) by supplying the Scholar with the means of carrying out original investigation in these subjects. The Scholar holds the Scholarship for three years and is eligible for re-election. The Scholarship is of the annual value of approximately £700.

The Arthur Durham Travelling Studentship

Candidates for the Studentship must be registered medical practitioners who have studied at Guy's Hospital Medical School. The Student is required to proceed abroad for the purpose of carrying out such investigations as may be approved or directed by the Board of Electors, and shall undertake to reside continuously abroad for a period of not less than six months. The Studentship is of the value of approximately £600.

The Sir Alfred Fripp Memorial Fellowship

The Sir Alfred Fripp Fellow is required to promote the advancement of knowledge and research in Psychology, more particularly through the study of children in health/and or disease. The Fripp Fellow is allowed opportunities for study in the Department of Paediatrics and the Department of Child and Adolescent Psychiatry and is required to submit with his or her application a definite scheme of advanced study or research to be carried out during the tenure of the Fellowship. The Fellowship is ordinarily for a period of two years but may be renewed for a further period of up to three years. Candidates must possess a registrable medical qualification and should not be more than 35 years of age. The value of the Fellowship is up to £1,220 per annum according to the seniority of the holder and the amount of time to be devoted to the Fellowship.

Dr. James Leighton Hopkins Travelling Scholarship

Candidates for the Scholarship must be registered Medical Practitioners, who trained at Guy's Hospital Medical School. The purpose of the Scholarship is to assist the Scholar to travel to gain further experience. The value of the Scholarship is up to approximately £820.

The Lambrinudi Memorial Scholarship

Candidates for this Scholarship must be male students who have completed their preliminary training in Orthopaedic Surgery and have held the post of Orthopaedic Registrar in a Teaching Hospital within the Commonwealth and who wish to further the study of Orthopaedic Surgery by postgraduate study, research or travel. The value of the Scholarship is approximately £400.

The Francis Lett Scholarship

Candidates for the Scholarship must have studied at Guy's Hospital Medical School. The Scholarship may be held by itself or in conjunction with other Studentships. The purpose of the Scholarship is to enable the Scholar to obtain experience in other Medical Schools or Hospitals, at

home or abroad. Candidates must submit their proposed programme with their application. The Scholarship is of the value of up to approximately £1,350.

The Hilda and Ronald Poulton Fellowship

The Poulton Fellow carries out research in the Department of Medicine under the direction of the Professor of Medicine and the object of the Fellowship is to increase the knowledge of the origin, progress, treatment and cure of obscure diseases in man. The Fellow is appointed for two years in the first instance with possible reappointment from year to year. He is required to work at least half his time in the Department of Medicine under the direction of the Professor of Medicine and may hold another appointment at the Hospital or School. The present value of the Fellowship is approximately £525 per annum.

The Adrian Stokes Memorial Fellowship

The Fellowship is open to registered Medical Practitioners or Graduates in Science, Pathology or Bacteriology. Applicants must be anxious to carry out further study in Pathology or Bacteriology in any of their branches. The Fellow is required to carry out this study during a period of not less than six calendar months in his year of tenure at a University, School or Hospital, or other institution, subject to the approval of the School Council except the School in which he has received his medical or scientific education. The Fellowship is of the value of approximately £1,100.

Notice

Physiotherapy Charity Ball 1979

The Annual Charity Ball run by the Third Year students of the School of Physiotherapy, Guy's Hospital is being held at

QUAGLINO'S,
Bury Street,
LONDON, S.W.1
ON FRIDAY, MAY 4th

All proceeds will be donated to Cancer Research and to the Charles Hawkins Fund, a charity set up by the Newcomen Centre of Guy's Hospital for the benefit of the children of Southwark.

DOUBLE TICKETS (Inclusive of Dinner) £16.00.

Please apply to: Miss E. M. FRIEND,
School of Psysiotherapy,
1st Floor Shepherd's House,
Guy's Hospital,
LONDON, SE1 9RT.

Guy's Hospital Physiotherapy and Radiography Association

The sherry party will be held on May 16th at 6 p.m. in Shepherd's House. Tickets at 30p per person are available from Miss J. A. Jones, School of Physiotherapy, with s.a.e.

Obituary

Dr. C. S. E. WRIGHT

Dr. Charles Samuel Eric Wright, of Greatford House, Hundleby, died recently at the Old Hall Nursing Home, Halton Holgate, where he had been living for some time, at the age of 93 years.

In spite of his age he had remained remarkably active and had been out walking regularly until a short time before his death.

Dr. Wright was born at Norwich, the son of Rev. W. S. Wright, Vicar of New Catton, on the outskirts of Norwich. He was educated at Cambridge and Guy's Hospital. He began his medical career as a house surgeon at Chesterfield Hospital, but the First World War put an end to his plans to enter into partnership with one of the surgeons at the hospital.

On the day war broke out he joined the Army and was in one of the first units to go out to France. He served throughout the war with the R.A.M.C. in France and Belgium with the rank of Major, and was awarded the Croix de Guerre.

At the end of the war he was in the Army of Occupation. He then came to Spilsby to enter into partnership with his late wife's brother, Dr. L. T. Dean, and had remained in the town ever since. He continued in partnership with Dr. Dean until they both retired in 1946.

His wife died in 1974, and he leaves one son, Mr. W. H. S. Wright, of Boston, and three grandchildren.

Dr. G. MEADOWS, M.R.C.S., L.R.C.P., D.P.M.

Dr. Guy Meadows died 15th December, 1978. He qualified during the 1914-18 War, was house surgeon to Sir Arbuthnot Lane and then served in the Royal Flying Corps and subsequently the R.A.F. After a brief time in general practice he became medical officer to Peak Freans and must have been one of the first full-time industrial doctors. He subsequently worked for the Imperial Tobacco Company in the same capacity until he retired in 1951.

He had been a widower for twelve years but leaves two sons one of whom is a doctor.

J. G. M.

F. H. MUIR

Mr. Frank H. Muir died on the 30th January, 1979, at the age of 80.

Mr. Muir was the Chief Technician in the Cardiac Department up until the date of his retirement on the 31st March, 1965, and he worked very closely in the early years with Lord Brock in his work in heart surgery.

Clubs' Union News

Most Guy's students, I think, consider that the main function of the Clubs' Union ought to be to arrange social events for the student body. In fact our constitution states that *"the object of the Union shall be to promote . . . social, cultural and athletic activities among its members"*. With this in mind several of us have been trying to organise a steady series of events for the summer term.

Inflams will be held at fortnightly intervals as usual and although these have been successful for years many of us feel that some variety is necessary. I am not suggesting that the format of inflams i.e., a disco held in the bar, be altered, as experience has shown that attempts to move out to the Table Tennis room have not been a success. But we would like to see more entertainment provided for the denizens of that subterranean hole (the Bar!). Richard Horne, the social secretary, is in the process of booking some local pub bands for alternate Wednesday nights so as not to clash with the *Inflams*. Once the professionals have broken the ice we hope that whatever talent in the field of folk singers or jazz bands, or whatever that lurks, will come forward to participate in these evenings.

As those of you who went to the *Inflam* on March 7th will know we had a check on all the people who went downstairs. This was achieved without inconvenience to the users of the bar and prevented a small number of "outsiders" from infiltrating. It was interesting also to discover that quite a few people were coming from other London Colleges despite the almost non-existent advertising that we provide for these events. The idea behind the check was that by being able to identify all the people who are downstairs it would be possible to name those responsible for any vandalism caused.

To return to events for the Summer term, the *Guinness Grand Union Medical Meander* will be held on May 12th and will again be between Rickmansworth and Little Venice. This annual event is sponsored by Guinness who provide appropriate refreshment throughout the course. This event is invariably over-subscribed and regular participants will be keen to fill the number of places allocated to Guy's students. A notice giving further details and "joining instructions" has been posted in Boland House. It is important that you sign up if you are coming as it will then be possible to book a coach to ferry you back and forth.

Also during the summer term we will be holding a few dances upstairs in the Ball room on Friday evenings. With the recent experience of the Barn and Valentine's Dances during Charities Week which were very well attended, there seems little doubt that these ought to be a success.

The *Union Shop* now has (at the time of writing) a full stock of Guy's Sweatshirts, and Deb Brooke and her colleagues guarantee the shop will be open between five and six p.m. on Monday and Tuesdays and between one and two p.m. on Thursdays and Fridays. We hope having appointed Chris Donovan as an "advertisement officer" that you will all be better informed about what's on.

At each of the last two bar committee meetings the figures for December, 1978 and January, 1979 were received. Now these two months are of course before Bob Long took over the job of bar secretary and started his month long surveillance drive. The figures for December, 1978 showed a cash shortage on expected profits of 8.4% of the gross turnover. This was the highest for some time but in contrast the comparable figure for January, 1979 is 3.9%. Less than about 2% would be considered acceptable by an average licensed premises. But we will clearly need a month at least before we can assess the efficacy of Bob Long's efforts.

As you will have noticed the prices of all the draught beers and many of the bottled beers have recently risen. This was because about half of the beers had risen by an amount which to maintain the same profit would have meant a two pence per pint rise. Rather than do this the bar committee agreed to raise the price of all draught beers by one pence a pint. Now as our constitution states that "the sale of intoxicating liquor . . . shall be so arranged as to involve the Union as far as possible in no financial gain or loss" and as the bar has made a very reasonable profit for a long time now many of us hope that the next few brewers' price rises may be absorbed without increasing prices to our customers. On that happy note I will end this "news report".

Chas Newstead, President.

Dietary carbohydrate in cardiovascular disease

by **PROFESSOR IAN MACDONALD**
Department of Physiology

There has been a considerable literature in recent years on the role of carbohydrates, notably sucrose, in the aetiology of cardio-vascular disease. Much of what has been written is speculative and this topic, like dietary fibre, has caught the imagination of the public. The amount of scientific research into dietary carbohydrate in cardio-vascular disease is small, and much of the work is in animals rather than man; to some extent this limited amount of research may be due to the chronic nature of the lesion as well as to difficulties in measuring vascular disease short of the ultimate event, namely arterial block.

What is the evidence that dietary carbohydrate is a factor in promoting cardio-vascular disease?

In 1961 it was reported [*Ahrens et al*] that dietary carbohydrate can give rise to an increase in the concentration of triglyceride in fasting serum, and other publications have stated a raised level of triglyceride in fasting serum is of value in the prognosis of coronary artery disease [*Albrink, et al 1961; Carlson and Bottiger, 1972; Nikkila and Avo,1973*]. However, the evidence that the fasting serum triglyceride level gives a good indication of coronary disease is weak when compared to comparable evidence relating to raised serum cholesterol levels, cigarette smoking and raised blood pressure [*Kannel and Gordon, 1970*].

Why is the incidence of cardio-vascular disorders low in those countries where the intake of dietary carbohydrate is high?

There are several possible explanations for this and these include:—

(1) death may occur at an early age, due to causes not seen in those populations with a high incidence of vascular disease,

(2) there may exist in those populations factors which may offset the effects of dietary carbohydrate, e.g. exercise, or the absence of factors that may aggravate them, e.g. smoking, hypertension,

(3) the genetic make-up of these populations is such that they do not react to a high carbohydrate diet in the same way as coronary prone communities,

(4) the type of carbohydrate consumed may be different. High carbohydrate consuming populations tend to take most of their carbohydrate as starch whereas in the U.K. about 50% of our dietary carbohydrate intake is as sugars.

Are some persons "carbohydrate-sensitive"?

There are persons whose fasting serum triglyceride levels will rise markedly when there is an increase in dietary carbohydrate intake [*Stone and Dick, 1973*], proportion [*Wood et al, 1972*]. In comparable age groups women are less sensitive until the menopause [*Wood et al, 1972*] than men.

The implication is that the "carbohydrate sensitive" are more prone to vascular disorders and there is a suggestion that this might indeed be so [*Fredrickson, Levy and Lees, 1961*] though the evidence is far from convincing in view of the positive association between "carbohydrate-sensitivity" and diabetes mellitus and over-weight, conditions which themselves may lead to early onset of vascular disease.

What conditions increase "carbohydrate sensitivity"?

Any condition which raises the insulin response to a standard glucose load will increase "carbohydrate sensitivity" and such conditions include diabetes mellitus, over-weight, use of the oral contraceptive [*Mann, et al, 1976*] and pregnancy. As the latter is a short lived state the long term consequence, vascular disease, does not develop.

Can, in those who are "carbohydrate sensitive", the presumed vascular consequences be offset?

If by "carbohydrate sensitivity" is meant the elevation of the fasting serum triglyceride concentration in response to dietary carbohydrate, then the answer is yes. When a polyunsaturated fat, such as sunflower, corn or soya oil, replacing the more saturated fats found mainly in animal products is consumed, along with dietary carbohydrate the rise in fasting serum triglyceride levels expected do not occur and in fact the triglyceride level may fall. [*Macdonald, 1972*]. Whether this modifies, in any way, the prospect of possible vascular disease resulting from the carbohydrate ingestion, is not known.

Are all dietary carbohydrates equal in their effect on the level of triglycerides in fasting serum and hence, by implication, on cardio-vascular disorders?

Fructose, and fructose containing compounds such as honey and sucrose [glucose and fructose] cause greater elevations of the concentration of triglycerides in fasting serum than dietary carbohydrates composed of glucose and/or its polymers [e.g. starch]. [*Macdonald, 1973*]. In the 85% or so of the adult population who are not "carbohydrate sensitive" this rise will probably not exceed the so-called upper limit of normal triglyceride concentration and hence be of little, if any, consequence. On the other hand, those whose fasting serum triglycerides are pathologically raised, have greater increases in this lipid after sucrose ingestion than after starch [*Kuo and Bassett, 1965*].

Is there any evidence that in patients with atheroma the metabolism of carbohydrates differs from that in the healthy?

It is accepted that diabetes is associated with an increased incidence of vascular disease but whether this is due to the disorder in carbohydrate metabolism or to another facet of this disease is not known.

Fructose metabolism has been found to be different in patients with peripheral vascular disease when compared to normal patients [*Macdonald and Turner, 1971*] and in patients with a history of myocardial infarction more dietary fructose and glucose is converted into serum triglyceride than in controls [*Macdonald, 1968*].

Does dietary carbohydrate affect the serum cholesterol level?

To a very minor extent only.

Does dietary carbohydrate affect the level of high density lipo-protein cholesterol?

The level of high density lipo-protein cholesterol, inversely associated with coronary disease and currently popular as a prognosticator of this condition, is lowered by dietary carbohydrate [*Schonfeld et al, 1976*] but not more so by sucrose than by glucose [*Macdonald, 1978*].

In summary it would seem that on current evidence dietary carbohydrate, either as starch or sugar, does not lead to cardio-vascular disease, except possibly in the 10% or so of the adult population whose metabolism seems to be "sensitive" to dietary carbohydrate, and in these people sucrose seems to be more likely to be a factor in arterial disease than starch or glucose.

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"The BBC in Retrospect"

by SIR CHARLES CURRAN, former Director-General, British Broadcasting Corporation

From a presentation to the Quodlibet Society, at Guy's Hospital.

When I was invited to give this talk I said that I would speak on the BBC in retrospect. I think that the best way for me to do that is to tell the story of one or two incidents of different kinds which took place during my time as Director-General. Some of them are about politics. Some are about problems of whether we were doing right by the audience. And one of them is about the background to a union problem which led to a strike.

The most interesting problems, I always found, were those which concerned our relations with Government—with the political power. Usually the situation is that the Government of the day wants the BBC to behave in a particular way and the BBC declines to do so. The first story of that kind which I am going to tell is about the general election of 1970.

The B.B.C. and Harold Wilson

Neither broadcasting organisation ever had an easy relationship with Harold Wilson, whether he was Prime Minister or Leader of the Opposition. Sir Hugh Green had experience of the difficulties as early as the election of 1966. My first difficulties arose, after an initial period of harmony, during the election of June 1970. The final *Panorama* of that campaign, to be broadcast on the Monday before polling day, was to deal with external affairs, with the emphasis either on defence or on the prospect of entry into the Common Market. Neither of these subjects had been prominent in the election campaign, but each was likely to be of major importance in whatever Government took office after the result of the poll was known. I had an arrangement, made personally with Mr. Wilson, that there should be consultation between the two of us, if

necessary operating through his staff at No. 10, about the selection of Labour speakers to take part in major programmes. I had agreed to this in order to avoid the risk that the BBC might seem to be choosing spokesmen for the Labour Party who would not be acknowledged by the Party as representing its official point of view. There was a danger, of course, that such an arrangement could degenerate into outright nomination by the Party of participants in programmes. The problem in such situations has always been that broadcasters depend on the willingness of spokesmen to appear, and at election time senior politicians are reluctant to incur the wrath of the Leaders of their Parties by accepting invitations from broadcasters in defiance of the known wishes of the Leaders. The device of the "empty chair" in a programme in order to signify the existence of a dispute between the broadcaster and the Party on the selection of a suitable spokesman is possible, but does not add greatly to the illumination of the audience or the subject. It is also a hostage to fortune for relations between the broadcasters and the possible next Government. I asked Mr. Wilson, indirectly, whether, in the event that external affairs was to be the subject of the *Panorama* in question, the then Foreign Secretary, Mr. Stewart, or the Secretary for Defence, Mr. Healey, would be the *"more likely to be available"*, making clear that the subject of the programme would be external affairs in general, including the possibility of the Common Market. The reply which I received, also indirectly, was that Mr. Healey would be the more likely to be available. I had no illusions as to the possible political significance of that message. When the producer of the programme decided that the emphasis was to be on foreign affairs rather than on defence and on the Common Market in particular, he knew of this message, though not of its provenance. He thought it right, in all the circumstances, in the exercise of his proper judgement as an editor, to invite the Foreign Secretary. Mr. Stewart, clearly uninformed about Mr.Wilson's views, accepted. The fat was in the fire.

Mr. Wilson made what I can fairly describe, with the greatest restraint, as the strongest representations to me that this was a breach of our understanding. I had to defend the action of my producer. In the end Mr. Stewart was instructed by the Party to withdraw. In the circumstances, the BBC invited Mr. Healey. But what was more serious than the reaction to the news of the producer's intention was the claim by Mr. Wilson that the Parties had the right to nominate speakers in such programmes. Although the dividing line was, in practice, very narrow, the BBC had to maintain that in the end the choice of speaker belonged to the broadcaster and not to the Party. The alternative, after all, to having Mr. Healey would have been to have the empty chair, and the broadcaster must always retain that option.

Relations with the Foreign Office

Nearer the end of my time there was a very similar incident, but it concerned relationships between the BBC and the External Services. You may well imagine that the activities of General Amin provoked problems for them in their broadcasts to Africa. The problems naturally concerned the Foreign Office, with its interest in the lives of British citizens, as well as the BBC, with its long term interest in its reputation as a source of reliable information. What happened was this.

When Mr. Callaghan was Foreign Secretary in the Labour Government which took office in 1974, Sir Michael Swann was equally strong in reasonable resistance to representations from the Foreign Office, and in the end, from Mr. Callaghan himself, that the BBC's External Services should not broadcast comment on a biography of Field Marshal Amin by David Martin. The Foreign Office view was that the author, a former BBC Foreign Correspondent, was so unacceptable to the Field Marshal that mention of the book in the BBC's Services to Africa would, in itself, be provocative and might perhaps result in the risk of pressure, and perhaps worse, against the remaining British inhabitants of Uganda. The BBC view was that while it was reasonable to consider the form in which mentions of the book might be presented, it would be unacceptable for a publication which was bound to be known to the audiences in Africa to find no reflection in the BBC's programmes. It is a requirement of credibility for the BBC, in addressing its overseas audiences, that the service of information should be reasonably complete, and should certainly include those matters which are likely to be the subject of common discussion among the audience themselves. The problem is one which must frequently arise. The Foreign Office is bound to consider the immediate practical circumstances, and the BBC is bound to hold to the long term issue of principle—that of editorial integrity—which underlies credibility. The representations which were made to me and to Mr. Mansell (then Director of External Broadcasting) from an official level in the Foreign Office were forceful. Those subsequently made by Mr. Callaghan to Sir Michael Swann were certainly not less forceful. Throughout, Sir Michael maintained the position which any Director-General must always hope to find in his Chairman—that the BBC must take its own decisions on grounds of principle, and be prepared to accept the public responsibility for their possible consequences.

My third example about relationships with Government comes once more from the overseas broadcasting field, but it goes in the contrary direction from the two which I have just recounted. It was an example of the BBC accepting the Government had good reasons for making a particular request, and acceding to that request. The basic incident is probably now long forgotten.

The Soviet Problem

When I was Director of External Broadcasting, our Russian Service acquired the exclusive rights to broadcasting the original Russian version of Svetlana Alleluieva's *Twenty Letters to a Friend*, published in the *Atlantic Monthly*. They planned to do so on the same day as the *Atlantic Monthly* was to appear, which made obvious broadcasting sense. However, on that day the then Mr. George Brown, who was Foreign Secretary, was in Moscow talking to the Soviet Government at a moment when the issue of war and peace in the Midle East was at its most acute. It was represented to us that the broadcasting of this item on that day could be seen by the Soviet authorities as proof of the untrustworthiness of the British Government and therefore as an argument for rejecting whatever overtures the Foreign Secretary might be making at that moment in order to preserve peace, or the chance of peace, in the Middle East, and therefore possibly in the world. I argued for many hours that the Russians would do what they wished to do, regardless of what we broadcast, but I was bound to recognise in my own mind that there might be something in the Foreign Office argument, and that the topicality

of the Svetlana Alleluieva article was not so absolute as to justify me in resisting to the last. When, therefore, it was put to me that the Prime Minister wished us to give the most serious consideration to a postponement of the broadcast until Mr. Brown had left Moscow—but emphatically *not* to a cancellation—I agreed that this was what we should do. I believe that these responsibilities cannot be the subject of decisions which relate solely to the interests of the broadcaster. There are occasions when other interests have to be weighed in the balance. But the frightening thing is that it is the broadcaster who must decide where the balance of interest lies. I can tell you that I do not find it easy to make such judgements.

Industrial Relations

But not all the Director-General's problems, which, of course, are those of the Board of Governors as well, are political. Last Christmas saw a very serious problem of industrial relations facing the BBC, with a total strike by its major union, blacking out all programmes for the first time in the history of the Corporation. During my time we had various rumbles of discontent. Indeed, one of them came right at the beginning of my period as Director-General, in the autumn of 1969. At that time, too, the BBC was being required to observe a pay guideline. I think, in those days, it was called a "norm", and the percentage involved was, to the best of my recollection, 2½%—a figure which seems remarkably low these days. Comparisons with other occupations would have suggested a 4% settlement, but the Government was not prepared to agree, and, as always in these situations, we were awaiting a decision on an increase in the licence fee. At the beginning of October the BBC's largest union, the Association of Broadcasting Staff, undertook its first strike action ever. No production whatever took place in the BBC's studios at Television Centre for about ten days, but the effect was not at all obvious to the public, because the stockpile of programmes and the availability of films, together with the readiness of management staff to maintain the service, meant that programmes continued with very little change during the period when labour was withdrawn.

We finally got out of that difficulty as a result of the calling of a Court of Inquiry which produced the principle that the BBC ought not to claim financial stringency as a proper ground for limiting pay awards to its staff. I should make it clear that it was not the BBC's wish to apply this stringency. It was Government pressure which compelled it to do so—the pressure being exerted by reference to the impending licence fee decision. We were happy to have it stated that inadequate finance was not a ground for denying our staff a just reward for their work. The application of that principle simply meant that Government had to face up to its proper obligations in the matter of the licence fee.

Some four years later, in the summer of 1974, we had the second major interruption of work in my time. It took place because an important category of staff—the Production Assistants in the Television Service Drama Department—felt that they were being unfairly treated in comparison with their operational colleagues who worked alongside them as a matter of routine. One of the consequences of the 1969 strike had been a settlement which recognised that operational staff working curious hours should be compensated for these "unsocial" conditions of work. That meant, of course, that operational staff who worked shifts and difficult hours were compensated by overtime and premium payments.

The BBC had long held that staff in the professional categories—those who did not work by the clock but by a sense of obligation—did not receive overtime payments, their special requirements being held to be rewarded in the basic rate of pay. The trouble was that the premium payments to operational staff soon began to reveal the inadequacies of the basic rates of pay in the more senior levels of the BBC. It is a common phenomenon in today's society. The Production Assistants were the most obvious victims of the system, in that those who scheduled their hours of work were inclined to regard them as dedicated professionals—which they were—but as dedicated professionals with no awareness of the financial comparisons which could be made with the operational staff working on the same productions. That, of course, was not true. It is impossible to work alongside other people and not know what they are being paid. So an undue reliance by directors and producers on the sense of duty of their Production Assistants meant that too little account was taken of the pay factors, and of the inadequacy of time off for those who were not being paid. The Production Assistants went on strike, with the full support of the union, and they stayed out for five weeks. In the end the strike was settled as part of the very substantial general pay award for BBC staff which immediately followed the ending of the Heath pay restraint policy in mid-July. By that time the new Labour Government was in office, and had not then proclaimed any general pay policy, because of the commitments which it had made to the trade union movement in the course of the preceding election. Pay awards which, in some cases, were as high as 24%, were made to the BBC staff in order to keep them in line with outside movements and the availability of that order of money meant that the grievances of the Production Assistants could be settled effectively by wiping out the many differentials which had prevailed between them and their operational colleagues. There were complicated details, but in essence they do not matter for the purposes of my argument.

The important point is not so much that there was a dispute as that there were legitimate reasons for it. One of the reasons was the neglect by managers of the justifiable feelings of their junior staff. The other was a change in the character of working for the BBC. To my mind—and I speak as an observer of the broadcasting scene for 25 years and not as a professional social scientist—there has been a change in the approach of people in broadcasting to their job. They are still as proud of their profession as they have ever been—and in some respects I think that their professionalism is greater than it ever was. But where it was once assumed by those concerned with the production of programmes that the job had an overriding claim on the whole of their lives, I doubt if that is true any longer. Any man or woman is free to give everything to the job, according to his own lights. But an employer on a substantial scale, such as the BBC, has to operate according to recognised rules towards the people he employs if petty and arbitrary local tyrannies are to be avoided. Moreover, a man or woman employed in a large organisation, no matter how splendid its purpose, has the right to be regarded as a member of a family at home as well as a member of a family at work. There is a tyranny of obligation which comes from a high sense of purpose, and which can oppress the individual if the organisation to which he belongs is not scrupulous in its regard for his personal liberties. What I am speaking of in the BBC is the change from the assumption

that all could be expected and demanded, to a condition in which much is still expected—and given—but a life of personal freedom is left to the individual. There are changes required in the temper of management when this change in attitudes occurs.

So far I have given you one or two recollections of political problems and of industrial problems.

Moral dilemmas of broadcasting

I want to finish with an ethical problem. What responsibility does the BBC have for the possible effects of some of its programmes? I am not going to talk about violence. That is much too complicated. I am going to talk about one series which I hope will be well known to you. When the BBC was producing *"Till Death Us Do Part"* we justified it on the ground that humour was the best destroyer of prejudice. We did, nevertheless, have an uneasy feeling that we might be contributing to reinforcement of damaging stereotypes.Our Audience Research Department therefore conducted a survey to find out whether the responses or attitudes of viewers had changed as a result of seeing the series. We found that there was little evidence to suggest the fears held by those who regarded the series as actually or potentially harmful. Five people out of every six saw Alf Garnett, the central character, as a harmless buffoon and good amusement. Two-fifths of the sample tended to regard his views as quite often reasonable. Analysis showed that liberalism and attitudes to foreigners were not significant factors in decisions to view the series. The survey showed, in general, that there had been little or no attitude change as a direct result of viewing *Till Death Us Do Part,* but that there had probably been some reinforcement of existing views, both liberal and illiberal. My own view is that *Till Death Us Do Part* was not regarded by most people as having any didactic purpose. It was, above all, entertaining, and that, I believe, is why it was a success.

I have given you an assortment of memories, I hope of some significance. If there is one thing which is enjoyable about the life of a Director-General, it is the variety of problems which face him.

Chronic Abdominal Distress
Is it in the gut or is it in the mind?

by **GORDON SLADEN**

Consultant Physician, Gastroenterology Unit

I was asked to write a brief account of some aspects of our Unit's work, which would be of interest especially to general practitioners and medical students. The topic I have chosen lacks the glamour of many hospital activities but is important because many patients are referred to us with symptoms which we cannot explain in conventional terms. For the student, the importance lies in the fact that these patients are not "taught upon" because they are not "interesting". Yet they have real problems, which we must attempt to resolve.

The medical gastroenterologist's technical skills are investigative and are thought by many to consist of little apart from endoscopy. I shall concentrate, therefore, on some illustrative examples of how we use these skills in an attempt to resolve certain problems. Our therapeutic skills are less appreciated because we have few difficult or mysterious treatment programmes and active intervention in chronic gut disease often involves surgery. However, I would submit that this emphasis is quite the wrong way round. We probably investigate too much and listen to the patients too little and the following examples will illustrate this more clearly than anecdotes or generalisations.

Upper gastrointestinal endoscopy and X-ray negative dyspepsia

In the first ten months of 1978 we performed routine endoscopy on 230 patients, excluding repeat procedures and emergency examinations for acute bleeding. In 57 cases (almost 25%) the reason for referral was ulcers (the X-rays had not been performed at Guy's) and two others had duodenal ulcers. Ten other patients had minor inflammatory changes in oesophagus, duodenum or stomach of dubious importance. The rest had absolutely normal examinations, confirming that the modern double contrast Barium meal is a very reliable examination. It is also much more comfortable for the patient than endoscopy.

Did the discovery of four ulcers influence their owner's management? We teach now that all gastric ulcers must be biopsied because they may be malignant, yet flat ulcers rarely are. We teach that cimetidine should not be given until and unless peptic ulceration is proved. This "rule" is widely flouted, but I would support it especially as we now know that antacid therapy (in adequate doses) not only relieves symptoms but heals ulcers. Why not use antacid therapy properly if the history suggests ulcer disease, irrespective of the X-ray findings? Short courses (4–6 weeks) of cimetidine provide an acceptable alternative to intensive antacids, but I would deprecate the continuous or repeated use of cimetidine without a firm diagnosis.

However, often the patient's history does not really suggest peptic X-ray negative dyspepsia. Of these, two patients had small benign gastric ulcer. It commonly suggests postprandial discomfort due to delayed gastric emptying or to gastro-oesophageal reflux and yet investigations are frequently negative. Reflux can sometimes be proved only by pH monitoring in the gullet but treatment based on history can be very rewarding. As far as delayed gastric emptying is concerned I clutch at two accepted "facts"—fat delays gastric emptying and maxolon (metoclopramide) accelerates it. Less fat with meals and maxolon before eating help many patients with X-ray negative dyspepsia.

The diagnosis that really affects management is gastric cancer and (based on Japanese experience) we should aim to diagnose these cases as early as possible in order to obtain good results from surgery. A short history of dyspepsia over the age of 50 years demands full investigation, especially if accompanied by weight loss or anaemia. So often it is too late for cure and, if we followed the Japanese example, we should gastroscope our prospective patients before they develop symptoms!

Is the pain arising from the pancreas or biliary tree? Use of ERCP*

Persistent abdominal pain or recurrent severe abdominal pain often gives rise to this question. In the great majority of patients with gallstones, oral cholecystography will either demonstrate the stones or will fail to opacify the gall bladder. Pancreatic disease is much more difficult to diagnose. ERCP allows examination of the upper GI tract and radiological assessment of the biliary and pancreatic ducts at a single procedure. It sounds attractive but the technique is difficult to master and can be distressing and prolonged for the patient. In the last 18 months Dr. Adrian Reuben has performed nearly 100 such examinations with complete (or occasionally limited) success.

TABLE 1

Indications for ERCP	Number of patients
Obstructive jaundice	18
Assessment of known pancreatic disease	6
Postcholecystectomy pain	11
Abdominal pain	59

Of the 70 patients, in whom pain was the major problem, 2 had stones in the biliary tree (not detected by other techniques), 1 had an unexpected gastric ulcer, 4 had changes of chronic pancreatitis and 1 had a malignant obstruction to the pancreatic duct, which precluded pancreatography. The yield was clearly very small and the abdominal pain remained unexplained in the great majority of these patients.

This group of patients provides a great challenge and management is very difficult. They are distinguished from the dyspeptic group by the persistence and/or the severity of their pain. Yet objective findings are absent and their general health does not usually deteriorate.

My clinical impression is that these patients are more likely to be psychiatrically disturbed than the dyspeptic group, yet we seldom seek psychiatric help. Stress factors are common but often denied (aren't they in all of us?) and occasionally depression is obvious. Nobody knows how to treat hypochondriasis but this can be recognised by histrionic and bizarre descriptions of symptoms.

Chronic diarrhoea. Should the patient have a jejunal biopsy?

Gastroenterologists are especially fond of coeliac disease and are most concerned not to miss this diagnosis, because treatment can be so rewarding. In a recent study of 70 consecutive patients having a jejunal biopsy, Dr. Ali Kheshavarzian noted the following indications and outcome (Table 2).

TABLE 2

Indications for Jejunal Biopsy	Number of Patients	Abnormal
Chronic diarrhoea alone	27	0
Chronic diarrhoea plus low serum folate	4	0
Chronic diarrhoea plus low serum folate and iron	5	4
Chronic diarrhoea plus low serum calcium	2	2
Steatorrhoea	11	2

*Endoscopic retrograde cholangiopancreatography.

In the remaining 21 patients the indications did not include diarrhoea, but rather such disorders as mixed deficiency anaemia, mouth ulcers and dermatitis herpetiformis.

Clearly most patients with chronic diarrhoea and normal haematological status do not have a jejunal mucosal lesion and, of 13 patients with coeliac disease seen during this period (almost 1 year), only 4 had had troublesome diarrhoea at any stage of their illness. We have now become much more selective in our use of this technique in patients with diarrhoea. It can be tedious and unpleasant for the patient, although it seems to be remarkably safe.

Chronic diarrhoea is a common reason for gastroenterological consultation, but in most cases the diagnosis is either made relatively easily by clinical or radiological examination or remains in doubt even after the most extensive investigations. We admit patients to the Metabolic Ward for such investigations relatively rarely, and try to avoid admitting them to the general wards.

5 day diarrhoea/malabsorption "work up"

Since the Metabolic Unit opened in 1977, we have admitted 22 patients with unexplained diarrhoea for the planned investigations shown in Table 3. We have admitted many others with Crohn's disease, gut resection etc. for similar tests.

TABLE 3

Planned Investigations in Metabolic Ward

Patients take a 70g fat/70g protein diet for 2 days prior to admission and, if possible, stop all constipating drugs (antibiotics should not have been taken for several weeks)

Day 1		24h urine for indican
2	Faecal Fat collection	24h urine for 5HIAA
3	Part 2 Schilling test— 24h urine	Screen urine, faeces for laxatives Bloods for VIP* gastrin etc.
4	C^{14} bile acid breath test	
5	and 24h faecal collection for faecal C^{14}	Lactose tolerance test

In this way we observe faecal volume, screen the patients for surreptitious laxative abuse, exclude small intestinal bacterial colonisation and seek rare syndromes associated with pancreatic and carcinoid tumours. All these patients had had GI radiology and a jejunal biopsy and (in many cases) pancreatic tests before admission. So far we have diagnosed 2 cases of laxative abuse, 2 of possible food allergy (this calls for yet further tests), and 1 of post irradiation malabsorption without radiological abnormality. Of the others, all but 2 had little or no diarrhoea in the ward (!) and the cause of the diarrhoea in these 2 patients has still not been elucidated. In many of the others the diarrhoea (still unexplained) recurred on discharge from hospital. We have not found any patients with unexpected small gut stasis (i.e. in the absence of obvious radiological abnormality) and have yet to find our first patient with a VIPoma". (VIP: vasoactive intestinal peptide—a potent stimulator of diarrhoea. VIPoma: tumour (usually pancreatic) producing VIP.)

Comment

This brief survey shows that we do a lot of technical work with negative conclusions, that we cannot explain many of our patient's symptoms and that we often have to rely on symptomatic therapy based on intuitive reasoning. I would hate to assess all this activity in terms of cost effectiveness. We spend a lot of time reassuring our patients but have little information about how effective we are. Symptomatic therapy is often effective in the short term, but what about the long term? My general practitioner readers can probably answer this better than I.

The Future

Presumably some explanations for chronic unexplained abdominal distress will be forthcoming. We are currently interested in the possible role of prostaglandins and food intolerance in some of these patients—a notoriously difficult subject to study, but one in which there is much expertise at Guy's.

The newer gastrointestinal hormones have attracted great interest of late and they have potent effects on many aspects of gut motility and mucosal transport. Yet the pattern of hormone release in response to food is similar in patients with the "irritable bowel syndrome" (a term which embraces many of the patients referred to above) and in normal controls.

Intestinal motility has been studied for years using increasingly sophisticated equipment. These techniques have described a number of abnormalities in patients with abdominal pain and bowel disturbance, but cannot explain why they occur.

Conclusion

I cannot answer my rhetorical question in the title, but I think that in the majority of the patients the problem is in the gut and not in the mind. The minority with primary psychiatric disturbances would include the frankly hypochondriacal with bizarre symptoms, the depressed with unclassifiable abdominal pain and those who surreptitiously abuse laxatives and, often, other drugs as well. The management of all these patients requires time and tolerance on both sides and one of the most difficult aspects is to decide when investigations should cease.

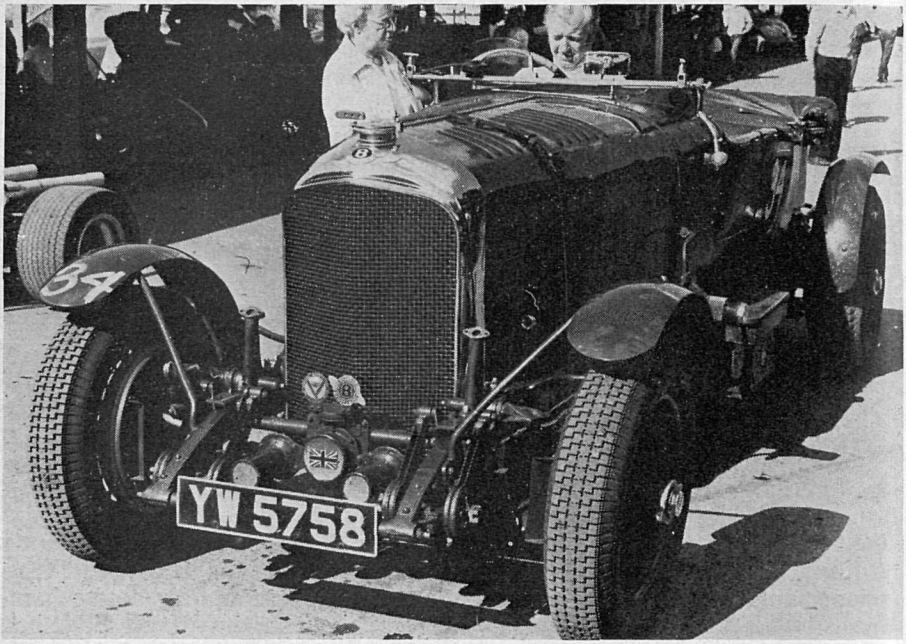
Outside Guy's—Continuing our occasional series in which people explain the fascination they find in their hobbies.

Bentley Boy

by **Timothy Houlding, Medical Student**

Just mention the word "Bentley" to any vintage motor enthusiast and a bugle shrills in his head, he stands a little straighter and a whistful look comes into his eye. He dreams of thundering green motor cars, Brooklands and that race of all races *Le Grand Prix d'Endurance des Vingt-quatre heures du Mans.*

In the space of twelve years Bentley Motors became a legend; an intangible weave of courage and daring, glamour and excitement spun by that most exclusive brotherhood, "The Bentley Boys"—a group of the Mayfair *Beau Monde* who could not boast a day's work among them. Sir Henry (Tim) Birkin, Baron D'Elanger, Earl Howe, Capt. Woolf Barnato (of diamond fame), S. H. C. (Sammy) Davis all rode their fiery steeds to uphold the honour of their beloved country, throwing caution to the winds and a good deal of Castrol "R" to boot.



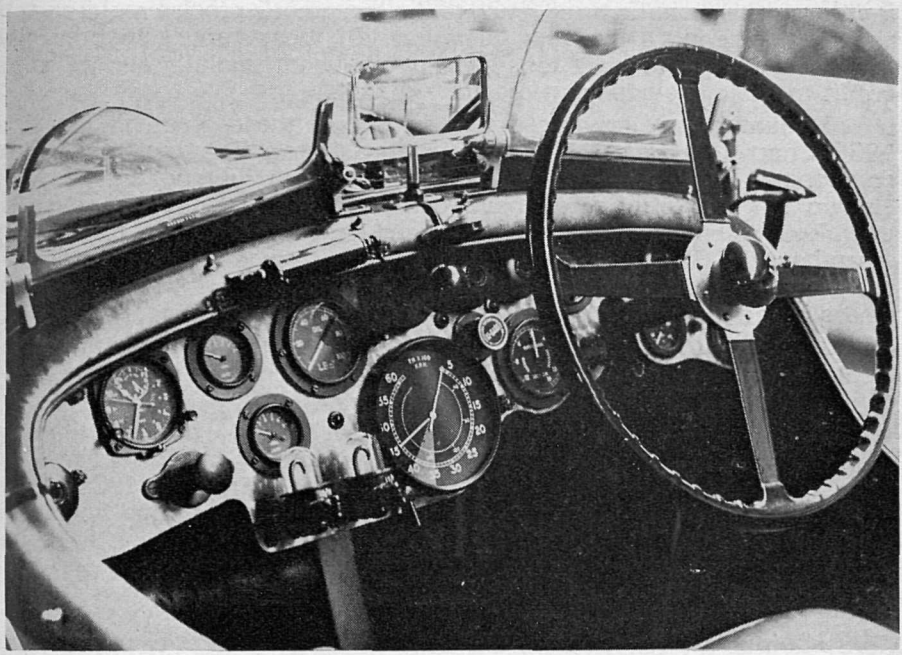
The 1929 "500" Miles Race Winning 4½ litre Bentley.

The story began in a mews off Baker Street, there is a plaque there to this day, in the early hours of one morning in 1919 when "W. O." Bentley and a small bunch of his engineers fired up the first three litre engine—totally unsilenced and with a scavenger oil pump that rattled like the proverbial half-skeleton in a biscuit tin, much to the annoyance of the Matron of the adjoining nursing home. Two years later the first production 3 litre emerged from the Cricklewood works and this model survived until well into 1928 when the 4½ litre superceded her.

"W. O.", as he is affectionately known, was a fine engineer who built his cars honestly and beautifully. A man who believed that power should come from litres and not a supercharger. His aim was to provide

a fast, reliable touring sports machine at a time when only Vauxhall were offering such in the form of the 30/98. The racing circuits of Europe were dominated by the French and Italians—Great Britain had not won a race in years and a win for Bentley would bring more publicity than a hundred Olympias.

Bentleys won five times at Le Mans, taking the first four places in the 1929 race, won umpteen races at Brooklands including the gruelling "Double-Twelve", and took a number of endurance records at Montlhery. The most famous win of all must surely be the 1927 Le Mans in which the whole team was involved in the infamous White House Corner crash, only one Bentley surviving with bent chasis to win the race and attract world-wide acclaim. England went wild with delight and a special party was held at the Savoy Hotel with the winning car present, "Old Number 7". The carpet, it is rumoured, never recovered.



The cockpit of a 1931 4½ litre "Blower" Bentley.

"Will you not covet such power as this . . ."—*Ruskin.*

The next model was the 6 cylinder 6½ litre, called the Big Six, designed for the more stately designs of coachwork and never considered a racing machine. In 1927 the 4½ litre emerged, the last of the long stroke four cylinder engines, the capacity of each cylinder being only a gnat's gall-bladder under 1,100c.c. It was this model which formed the basis of that most famous and contraversial of all Bentleys—the Supercharged 4½ litre or Blower Bentley—immortalized by the Bentley

Boy Tim Birkin and by a hundred young blades since, including the inimitable James Bond. There is a most marvellous account of a chase between Bond in a Blower and Sir Hugo Drax in a Gull-Wing Mercedes in *Moonraker.* The Blower 4½ never won a race but managed a second in the 1930 French Grand Prix at Pau. Imagine, if you will, a car weighing a little short of two tons in touring trim, minus mudguards and lamps, thundering around at speeds up to 120 m.p.h., equipped with a 45 gallon fuel tank and nothing more than aero screens for protection!

The true *Grande Classe* Bentley must be the 8 litre, built to compete against the Rolls-Royce Phantom II. If you could afford the £2,500 odd to buy such a machine, you could tour in style up to a guaranteed speed of 100 m.p.h. but with an 8–10 m.p.g. consumption to remind you of the performance. It is interesting to note that of the 100 8 litres built, 78 are known to exist today—a tribute to their reliability and ruggedness.

In the ten years of production (1921–1931) just over 3,000 Bentleys were manufactured, each to the customer's precise requirements and each carrying a five-year guarantee. Of those cars, something like 1,500 are known to exist today, many are used regularly and all are a credit to their designer and creator "W.O.".

I count myself privileged to own one of these great machines, a 1930 *Short Chassis 4½ litre four seater tourer.* The car consists of components from many 4½ litres as a complete running car lies way beyond my pocket. Spares have come from the Aladdin's caves of countless enthusiasts and other sources—the chassis was found on a scrap-heap in Glasgow, the steering column from a similar source and the front axle from the back garden of an elderly gentleman in Epsom where it had lain under a piece of corrugated iron for 29 years!

Although at present in a million pieces it should one day, after what will be an eight year rebuild, take to the road in much the same condition as originally produced.

Be they shabby or immaculate, a real Bentley bears a timeless dignity, and a purposefulness which points in only one direction—the open road. When Rolls-Royce bought Bentley Motors in 1931, many wept into their bitters at the rape of the Old Name, but the bugle still shrills and the dust and smoke of Brooklands and Le Mans have not settled yet.

Consultant's—G.P.'s Meeting. 1970.

Guy's Casualty

by Major General N. C. Rogers, Clinical Superintendent

General Practitioners share a mutual interest in Casualty Departments with the staff of the Casualty and the Hospital. I shall touch on a few matters of interest for our discussions.

Casualty

The title *Accident & Emergency* was substituted for *Casualty* by the Ministry of Health, hoping to define the limit the activities of the

Gazette Prints

The *Gazette* has produced full-size photo-facsimiles of three pen and ink drawings by Hanslip Fletcher of Guy's Hospital and its environs, on matt-finish high quality paper suitable for framing. The three designs available are reproduced on the following pages:

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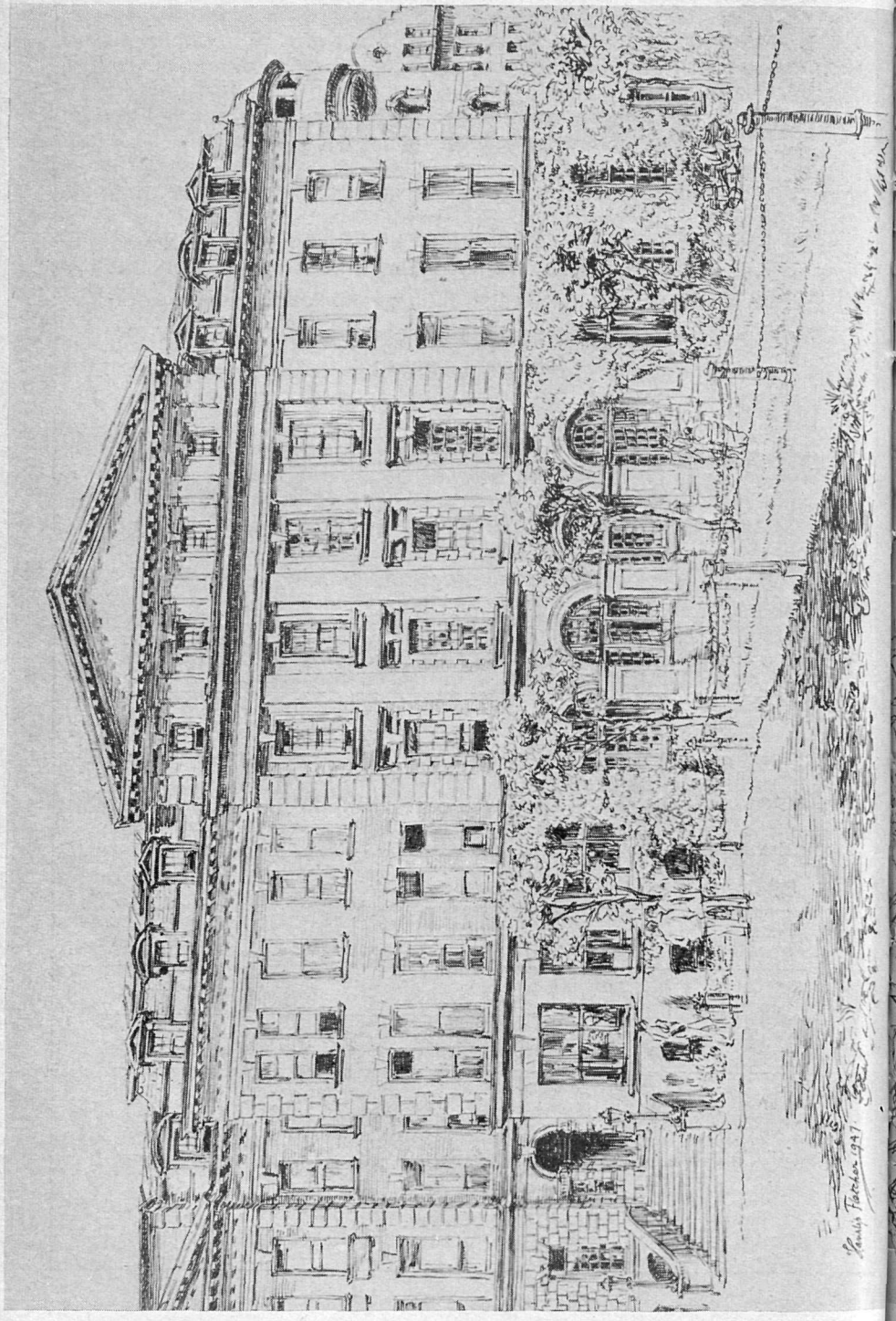

The Medical School 1947

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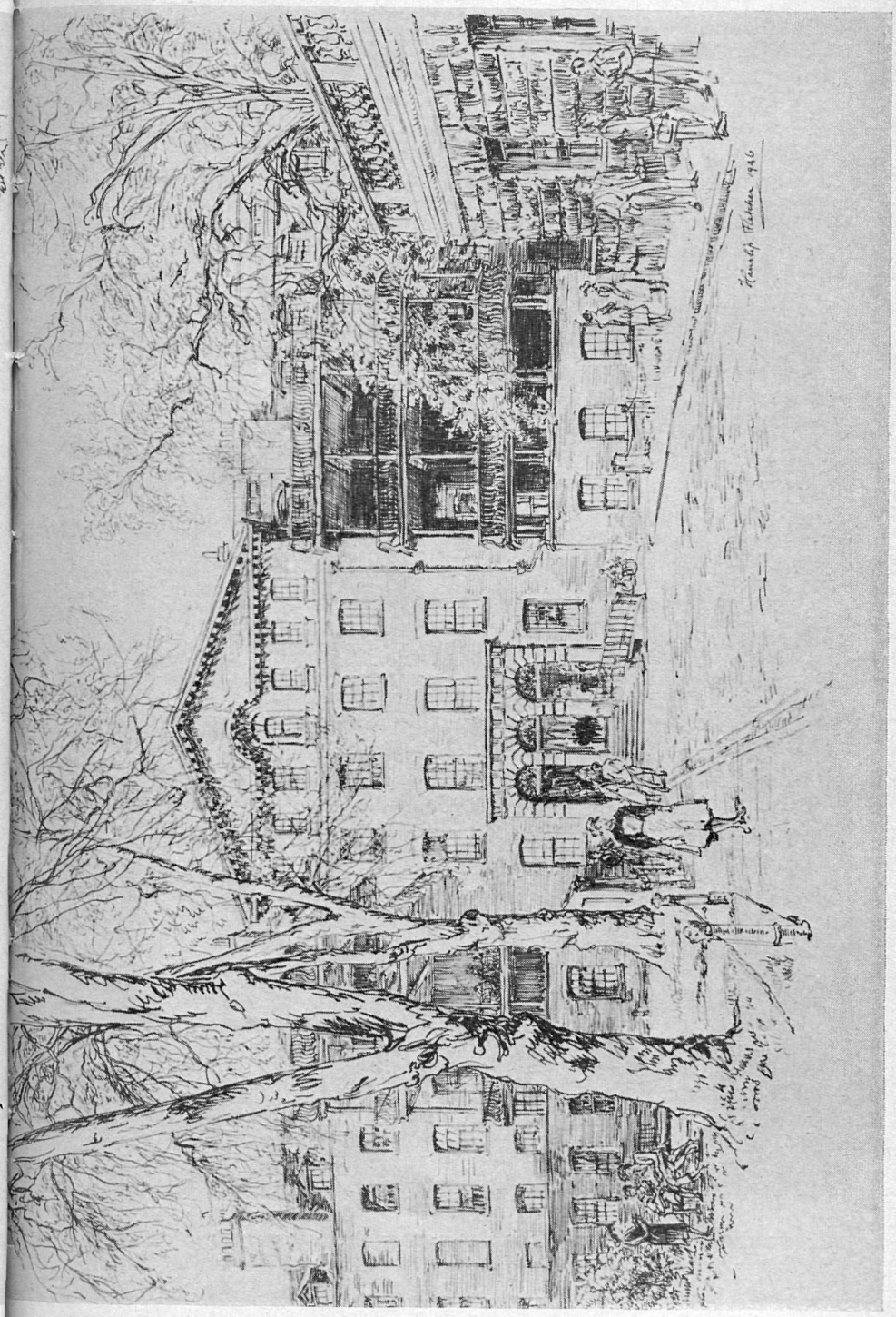
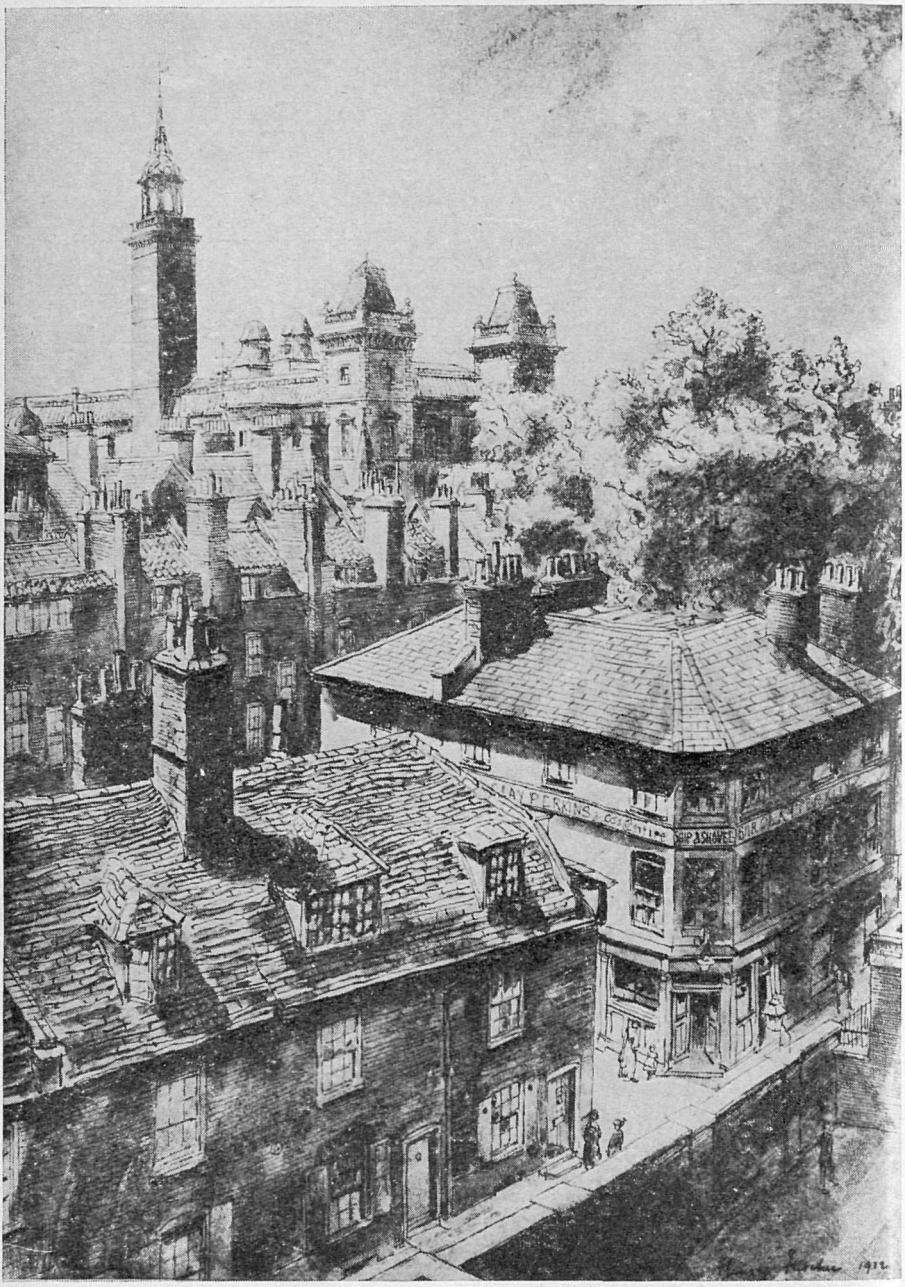


The Park 1946



"The Ship and Shovel" 1912

department. This action did not apparently influence a trend to greater use by the general public and the numbers of patients attending Casualty Departments rose steadily: at Guy's, new patients rose from 28,000 in 1966 to 42,000 in 1973 and 48,000 in 1977. Similar rises in numbers occurred at hospitals in Britain and the U.S.A.

Within Guy's the department is still known as Casualty, a title which has much to recommend it, being short, descriptive and involving the sense of the "casual" attender. We treat many casuals who may be local inhabitants, members of the staff, commuters, visitors to London or members of the large vagrant population of Southwark. During weekdays roughly half the patients are commuters, at weekends the majority come from local groups.

Policy

Anyone seeking aid receives it. The patient's name must be entered in the register and a casualty card started. The patient is not asked if he has attended his own General Practitioner, nor is there any notice to this effect.

On completion of care the patient is normally given a copy of the Casualty Officer's notes in an envelope addresed to his General Practitioner, and asked to deliver it at a surgery or sooner if his condition changes. In this way we hope to inform the doctor and encourage the patient to visit him.

Shape of the Department

The shape of New Guy's House was influenced by the ward design and in this it has been successful. The Casualty Department was introduced, reluctantly, on the ground floor, realising that a long narrow department built along a corridor is a bad shape for a Casualty. With the delay in implementing the phase 3 redevelopment of Guy's, we have been working to overcome this problem. The first step was the improvement of the reception area, which included an adequate reception desk and increased space for trolleys, a resuscitation room, a larger dressing room and a distressed relatives room. There is an imaginative plan prepared to increase our resuscitation and trolley bay areas, but this will require internal reconstruction for which the finance is not available at present.

Paediatric Casualty

At the time of the closure 3 years ago of the Evelina Hospital for Sick Children in Southwark Bridge Road, a separate Paediatric Casualty Department was opened at Guy's in an area adjacent to the main Casualty. It has a separate entrance, its own reception and a staff trained in paediatrics. It is open from 8.15 a.m. to 9 p.m. At night children are seen in the main Casualty by a member of the paediatric department. The size, shape and position of the department allows a suitable atmosphere for parents and their children separated from many of the more turbulent aspects of main casualty. This unique arrangement has worked very well.

Medical Students

Medical students attend an introductory session for familiarisation in casualty during their pre-clinical course. Later they join in the casualty

for 2 weeks of their 8 weeks surgical appointments, in which they are attached to a general surgical firm and the orthopaedic department. This arrangement is the subject of criticism because the students attention is divided in a short programme. Students in their early months of clinical work are naturally interested by the variety of casualty and join in the work with enthusiasm. Stress is laid on writing good casualty notes, an art requiring selection which differs from the more comprehensive ward note.

The Royal Colleges

The Royal Colleges of Physicians and of Surgeons, as well as associations such as the British Orthopaedic Association, have taken interest in the development of Casualty Departments and the training requirements of casualty staff. The Casualty Surgeons Association composed of consultants to casualty departments, is closely involved as well as the Royal College of Nursing. Slowly these efforts are proving valuable. I do not know of any involvement of general practitioner representatives.

A History of Guy's Hospital Rugby Football Club – 5

by Mr. T. L. T. LEWIS

The Centenary

The honour of captain of the club in its centenary year 1943–44 fell to Alan Lee. As part of the centenary celebrations, three matches were played; Guy's Past against the Present, Guy's first fifteen against a representative London Rugby Union side, and Guy's against Past and Present Rugbeians, played on the historic close at Rugby School, where the game is reputed to have begun in 1823. R. A. P. Hogbin, still playing well, was captain of Guy's Past. They held their own until half-time, when the score was 5—3, but eventually lost 33—3. The Centenary match, which was the occasion of a great gathering of former Guy's Rugby players, is reported elsewhere (see page 616). Guy's managed to win their match against the Rugbeians in front of a large crowd, in spite of giving up D. M. Strathie and A. Batty Shaw to the opposition. Early in the season, M. R. Mullins, A. G. Albers and the writer returned to South Africa in order to join up. It was sad to learn later of the death of Ally Albers from a fall while he was climbing Table Mountain. During the season, D. M. Strathie, who played for Thornloe's fifteen, R. D. Willcock and G. Hildick-Smith left the hospital. The team was not very successful, winning only eleven matches out of twenty-six. E. W. Graham came in at stand-off, Carl Ziervogel appeared again as wing forward for Guy's, and D. L. Gullick, R. A. Dean, D. R. Edwards and I. H. Hilliam, P. J. Dwyer, D. G. Jones and P. S. Carton-Kelly also played. Alan Lee played for the Barbarians, and Eric Graham and Tony Batty Shaw played for London against the Dominions. At the end of the season, Mr. W. D. Doherty succeeded Mr. T. J. Evans as President of the Club.

After the War

After the war the South African influence at Guy's was felt once again with men like A. J. de Villiers, A. C. de B. ("Bull") Eksteen, John Keeling, Frank and David Le Clus, Piet Rademan, F. J .("Kobe") Van der Westhuizen, F. Retief, W. J. Wolfsohn and A. Norman du Plessis playing a prominent part. Of these, Bull Eksteen, with his long spade beard, was one of the more colourful, and it was with great sadness that we heard of his death in a car crash. John Keeling hooked for England in 1948, and it is of interest to note that of four Guy's men who have been capped since the war, three have been hookers; Keeling, N. A. Labuschagne (England 1953 and 1955), who played mainly for the Harlequins, and W. T. Treadwell (England 1966), who was capped while he was playing for the Wasps. J. R. C. Matthews (England 1949, 1950 and 1952), second row and a great line-out forward, was also capped after leaving Guy's while playing for the Harlequins. It was with some satisfaction that in January, 1946, Guy's, having beaten Nuneaton, Leicester, Rosslyn Park, Wasps, Richmond-Blackheath, and drawn with Cambridge University, played Harlequins for the last time at Twickenham and beat them 10—8. The 'Quins refused to give us another fixture because they considered we were not good enough! The cup final, which unfortunately, we lost to St. Mary's, was played that year in front of the King and Queen. The writer and that splendid wing forward, Mike Hatton, represented London against the Kiwis. Also in the team then were Dave Potter, now in Australia; Bruce Cole, Oxford heavyweight boxing champion; Ken Heber and David N. H. Owen on the wings; A. G. McCallum and R. A. Dean, Murray Strathie and P. D. V. Harrett.

Harry Brunow, who played at stand-off for the Springboks, came to Guy's early in 1947 as a postgraduate from Cape Town, and was therefore not eligible to play in cup matches. He took the place of Murray Strathie, who became severely ill and recovered after several abdominal operations only to die tragically from serum jaundice some time later in 1948. Brunow was captain for two seasons, 1947–48 and 1948–49 (the year a dropped goal was reduced to three points). He himself was completing his training as a thoracic surgeon when he died of leukaemia before he was able to return to South Africa. During the first year of his captaincy Guy's won the cup in 1948 against St. Mary's. In addition to most of the South Africans mentioned above, Noel Malyon, B. M. Gray, T. K. Walker, Alan Lee, Peter Harrett, D .F. Cottier, Bruce Cole, Mike Hatton and the writer played.

Cup Final Incident, 1949

The following year an extraordinary incident took place. To reach the cup-final, which was once more against St. Mary's, Guy's had had to play the Middlesex three times in the semi-final, drawing the first two games. With only a minute or two to go in the final with St. Mary's, Guy's were in the lead 5—3. The excitement was intense. B. M. Gray on the wing, had to throw the ball in from touch, but it took him a while to find it among the milling, cheering spectators. When eventually he appeared with the ball, Arthur Rees, the referee penalised him "for deliberately wasting time". Guy's withdrew to their goal line and waited anxiously for the place kick from the touch line by Beatson. (At that time it was not allowed for the kicker to touch the ball after the kick until it

had gone forward ten yards). Beatson, however, tapped the ball with his foot and ran like a hare *behind* a group of spectators who were standing on the field, and he touched the ball down in the corner without a Guy's player laying a hand upon him. To everyone's amazement Arthur Rees awarded a try to St. Mary's and the cup was lost. It was open for Guy's to protest to the Rugby Union, but because it was rumoured that St. Mary's were going to share the cup, no protest was made. An offer of a replay was declined and St. Mary's kept the cup.

Playing at the same time as Brunow, was the Australian international wing forward, D. H. ("Doug") Keller, who also came to Guy's for postgraduate training. He played for the London Scottish as well as Guy's, and was capped for Scotland seven times in 1949 and 1950. B. M. Gray, who joined Richmond on leaving Guy's in 1950, was one of the most forceful wing three-quarters who have played for the hospital. He was a regular member of the side for five years. It is a mystery why he was never selected for England. W. Gwyn Davies was a fine line-out and loose forward, who captained Guy's for two seasons 1949–50 and 1950–51. David Le Clus scored many tries on the wing for the hospital before he moved to full back, where his kicking was a great asset.

1950's

The results form the early 1950s were not so good as previously, though many games were lost by only small margins, and notable wins were obtained from time to time. On average, the hospital won about one-third of its matches in each season, and points against were always more than those for. Guy's tended to have good forwards such as Jimmy Kirkbridge, D. K. Fairweather, Hubert Meredith, C. W. Pook, A. A. Craigen, Bill Lund, N. W. Glendinning and A. Van den Berg ("Van"). W. J. Howells at full back, was outstanding. For some years from 1953 an attacking midfield triangle of G. W. Hackett (later of the London Irish), Max Lindsey and Dick Hawley made a great difference to the three-quarter line, all three playing for their counties. In 1953, S. A. R. ("Stan") Cooke arrived from South Africa. He dominated the scrum from the back row and the line-out for some years, and was made captain for two seasons, 1954–55 and 1955–56. During this time J. D. ("Des") Carroll was playing very soundly at full back, and N. A. Labuschagne was hooking most successfully for the hospital. They were joined by two outstanding wing forwards, M. A. H. Russell, another South African, and D. A. Lillicrap. Containing individual players of talent, these sides had considerable potential on paper, but although they reached the heights on occasion, they were not consistently good for various reasons to be mentioned later.

The Guy's Cup in South Africa

In 1955, Guy's were in the cup final for the first time for six years. They drew with St. Mary's once in the semi-final, and won the replay, only to lose 9—3 in the final to the London. Later in the year the President, Mr. H. J. B. Atkins, in a ceremony at Groote Schuur, presented "The Guy's Cup" to the Universities of Cape Town and Stellenbosch. This cup was given as a token of friendship from past and present members of Guy's R.F.C., and is competed for annually by the two Univer-

sities. Attending the ceremony was the Cape Town rugby coach, Dr. Louis Babrow, Guy's captain in 1939–40.

"Royal" Visit

Guy's reached the final of the cup again in 1956. This presented John Zorab, one of a quintet of brothers who all qualified at Guy's, with a glorious opportunity of providing some royalty to attend the match. The whole plot was conceived and executed within twenty-four hours of the kick-off. At ten minutes to three on the day of the match, H.H. Princess Christina of Schleswig-Holstein, in a wide brimmed Ascot hat (Miss Bain, a first year dental student), the Dowager Countess of Blakeley (Mrs. Zorab, the very game mother of the family), a lady in waiting, and two private secretaries were assembled in a hired Rolls Royce at Richmond station. Their arrival at the ground threw the United Hospitals officials (of which the writer was one) into a complete panic. They had made no preparations to receive the Princess because when they had been informed the day before of Her Highness's wish to attend the game, they had cunningly telephoned the German Embassy and had been informed that there was no such person in England. Nevertheless, here she was! "Wait till I tell the German Embassy what I think of them," said the President, Mr. Alec Palmer, of King's, to the Treasurer, Mr. Scotty Law. Part of the front row of the stand was hurriedly cleared, but to make matters worse the Private Secretary complained sharply that the Princess expected the privacy of the Committee Box. This in turn was duly cleared of consultants and their wives and the Royal Party installed. Many of the finer points of the game were explained to the Princess by the Guy's President, whose pipe remained unlit at the request of her Highness. She was entertained to tea (which was intended for the consultants) at half-time, and invited to give the cup away at the end. The match, which was against St. Mary's, unfortunately ended in a draw, so the cup was not presented. At the end of the game the Royal Party were prepared to escape into the crowd because they had not been able to afford to keep the Rolls waiting. However, to their amazement, it was ready in a position to receive them, and they drove off in style, quite undiscovered except for a few fellow students, who kept quiet. The chauffeur had received an order to be somewhere at four-thirty, and mistakenly thought it was to be at Richmond. Credit must be given to Mrs. Zorab, who behaved with great dignity throughout and gave the Royal Party an unquestionable air of authenticity. The Princess did not appear at the replay which St. Mary's won 16—0. Playing in the team were two fast wing three-quarters, Colin Evans and John Leyshon. Dick Hawley was in the centre and with him were M. Lindsey and G .A. Hackett. L. Phelps was scrum half. In the scrum were J. Van den Berg, M. Russell, D. M. Smith, H. Meredith ,T. A. H. English, Stan Cooke (captain) and A. Buirski. Dick Hawley was captain in 1956–57, and he was followed for two seasons by Aubrey Buirski, a bullocking back-row forward who came to Guy's from the home of Dr. Danie Craven, Stellenbosch, South Africa. At the beginning of the 1957–58 season, Buirski wrote a letter to the *Gazette* accounting for the failure of Guy's in recent years as being due to apathy, lack of discipline within the club, and a low standard of physical fitness. Pointing out that Guy's rugby was at the cross-roads, he called for team spirit and summer training to overcome these deficien-

cies. He also arranged for Danie Craven to conduct a training session and to talk to a large and appreciative audience in the Physiology theatre. These efforts were rewarded by a better season, but the cup eluded us again, St. Thomas's beating us 6—3 in the final. In 1957–58, Buirski had with him in the scrum, W. Mike Patterson, Cambridge University hooker, Derek Richards prop, and Peter Harris and Barry Blackwell, who were to remain together as a tower of strength in the second row for several years; in 1958–59 he had D. R. A. Lloyd-Edwards (later to captain the Navy) and Ian Baker at wing forward, V. E. Egwuatu and Derek Biggs on the wings, Dick Hawley and C. J. Wright in the centre, N. F. Boyd and J. R. D. Nicholas at half-back, and K. M. Pagliero at full back. It was with great sadness that we heard of the death, in South Africa, of Aubrey Buirski and Frank Le Clus from coronary thromboses.

1960s

Barry Blackwell was captain in 1959–60, and Terence English in 1960–61. A South African with a B.Sc. in engineering, English first played for Guy's in 1955. Undecided about his future, he spent two years prospecting in the Yukon before returning to Guy's in 1957. Mr. J. S. Batchelor succeeded Mr. H. J. B. Atkins as President. To Blackwell's team-building and English's leadership must be attributed Guy's success in the cup in 1961. They had some difficulty in beating Bart's in the second round, being held to a draw before winning the replay. Against the betting, Guy's beat St. Thomas's 9—6 in the final. The incredible hooking of Bill Treadwell, aided by J. Hockey and A. Knight, Blackwell and Harris collecting the ball in the line-outs, the back row work and lethal spoiling of Cooke, English and Lloyd-Edwards, meant constant possession of the ball for Norman Boyd and Mike Murray to use the touch line and take the heart out of the opposition as planned. Determined running by Derek Biggs and Egwuatu got them inches from the line several times, and it was Biggs who dived over for the winning try. *The Times* seemed to capture the spirit of cup rugby when they reported: "As always, and particularly where Guy's are concerned, the preliminaries to the match were violent and noisy. It was the Guy's pack who dominated the course of the match. Sometimes they were almost terrifying, and every single one of them played a heroic part, although it was as a convulsive yet co-ordinated unit that they did their damage. In tight, loose and line-outs they were dictators, as it were, picking up their opponents, shaking them till their teeth rattled, and then throwing them away."

Biggs and Egwuatu were among the best wing three-quarters in the country. "Eggie", a Biafran, learned the game at Guy's, was fast and heavy and in full flight almost unstoppable. Unpredictable, he even surprised himself on one occasion when running for the line he found his way blocked, attempted a cross kick, and dropped a goal a few yards out from the corner flag.

Weaker Fixtures Rejected

At the Annual General Meeting of the club, in 1960, the Fixtures Sub-committee, claiming that repeated heavy defeats were bad for Guy's, recommended that some of the stronger fixtures should be dropped and

weaker ones substituted. This was rejected by a narrow majority. Barry Blackwell, in the *Gazette* of 13th January 1962 gave various reasons why he thought that the standard of Guy's rugby had declined and repeated the advice to reduce the strength of the fixture list. As examples of consistently poor results over ten years, he mentioned no wins out of ten matches against Cambridge University, one win out of seventeen matches against Aberavon, and two wins out of eighteen matches against Coventry. Blackwell's letter stimulated a lively correspondence from past and present Guy's rugby players. Some agreed with him and others did not.

Adrian Lloyd-Edwards led the side in 1961–62 and 1962–63, Ian Baker in 1963–64 and 1964–65, and John Davies in 1965–66. In spite of the efforts of these fine players and others like Peter Peace, J. M. Cockburn, C. Neville, A. Kingdon, R. Stansfield, Roger Brown, Hugo Sharp, E. S. Price, D. Gourley and J. D. Bryant; of Bob Myall, Arthur Morris, John Ross, Ashley Edgar, Peter Swift, Hamish MacGregor, M. D. Murray and Brian Rowlands; of Ian Morgan, "Eggie" Egwautu, Derek Biggs, Chris Wright, John Hockey and Bill Treadwell, the results were disappointing. 1965–66 seemed, however, to be the turning point. It was the first time for many years that we won more games than we lost, and we also won the cup and the United Hospitals Seven-a-side tournament. Having fought one drawn game, Guy's beat St. Thomas's in the cup final replay 3—0, Brian Rowlands going over for the only try. Guy's had therefore won the cup 29 times, 12 more than their nearest rival, St. Thomas's. Dave Elliott was outstanding at full back, Kingdon and Peace were superb in the line-out, and J. M. Cockburn, H. C. Sharp and Charles Thorburn carved up the opposition from the back row of the scrum. Max Lindsey, back at the hospital to do anaesthetics, played a sound game in the centre. Bill Treadwell, playing for the Wasps, was capped for England. Charles Thorburn, who came from Oxford University, played in the Scottish Trial, for the Barbarians and for the British Universities XV. Incidentally, the writer, while President of the United Hospitals R.F.C., played in a match for the first fifteen at the end of the 1966 season, twenty-seven years after his original appearance for the side in 1939. This, he claims as a record, together with the fact that in 1949 he played in the cup competition after being appointed to the consultant staff of the hospital.

Last two Seasons and the arrival of Hugh Burry

The last two seasons in this review 1966–67 and 1967–68, both while the team was under the captaincy of Charles Thorburn, were the most successful since the famous early 1920's. Not since 1920–21 has the team scored more than five hundred points. The results are worth recording:

1966–67. Played 34, won 23, lost 10, drawn 1. Points for 502, points against 227.

1967–68. Played 31, won 20, lost 10, drawn 1. Points for 556, points against 146.

The marked improvement in the rugger at Guy's is in no small measure due to the enthusiastic coaching of Dr. Hugh Burry, recently appointed Consultant in Physical Medicine at the Hospital. He played for the All Blacks in 1960 and toured South Africa with them. He came

to Guy's in 1966 to complete his training in physical medicine and straight away took a keen interest in Guy's rugby. With an emphasis on fitness and discipline his enthusiasm has been infectious and he has moulded a group of very talented players into a remarkably effective unit. What is even more important for the future he pays particular attention to the junior teams and while there are seven sides with regular matches on a Saturday he should not lack for material.

In 1966–67 the full back was Dave Elliott (who once reached the 9th green at Wentworth, a distance of 525 yards, with a driver and a seven iron on a wet day). Willy W. Davies was a deputy with a remarkably good place kick. J. M. Ross was one wing three-quarter, who, on his day, is as good as any in the country, and Ian Morgan, on the other wing, is a champion hurdler. The centres were the elusive R. J. Beacham and the forceful D. J. Osborne; the halves were Brian Rowlands and Peter Swift, each a potential match winner. In the front row were John Davies in his fifth season, G. B. Hey, the Kent hooker, and A. J. Kingdon; J. M. Cockburn, C. G. Neville or P. K. Peace in the second row, and D. A. Curzon, H. C. Sharp and C. W. Thorburn at the back. One of the highlights of the season was the second successive win 8—3 over Gloucester in the presence of their President, Mr. Arnold "Doc" Alcock (Guy's 1903–07). We fared badly in the Senior cup, but won the Junior cup. At the end of the season a successful tour was made in the North West, and games played against Waterloo, Fylde and Vale of Lune.

1967–68 was even better. For the first time for many years, we beat Cambridge University 8—0. We were successful also against Bedford, Wasps and Nuneaton. The team was similar to that of the previous season with the exception of J. Novak, a powerful runner who has played for the Harlequins on the wing, M. Cheesborough and J. F. Price in the centre, G. C. Voss deputising for the injured Hey with J. Stoneham acting as prop and M. Forbes coming into the back row. One of the biggest disappointments was our losing the cup final to the London, 6—3. Guy's camped out for the whole of the second half in their opponents' twenty-five, but were unable to penetrate a heroic defence. Although the Hospital seven did not reach the finals of the Middlesex Sevens, they did well to lose to Harlequins in the final of the Esher Sevens.

During the season, Charles Thorburn was captain of Middlesex when they beat Warwickshire for the County Championship, and he played in another Scottish trial. Novak, Swift, Hey, Price, Beacham, Peace and Neville also played for their county. In the United Hospitals Centenary Match, W. T. Treadwell, D. A. Biggs, J. A. Edgar and J. E. Davies played for the President's team, and Elliott, Neville, Price, Rowlands, Swift, Thorburn and Willy Davies played for the United Hospitals.

In one of the very last games of the 124th season, Guy's scored 80 points off the Old Haberdashers without three of their regular players. This is believed to be the highest score ever in a first fifteen match. Let us hope it means well for the future of the Club.

In writing this short history of Guy's R.F.C. I have referred repeatedly to old *Gazette's* and I have quoted freely from Dr. Alfred Allport's article in the Bicentenary Number of the *Gazette* January 6th, 1925. I have also been much helped by a manuscript prepared by the late Mr. G. A. R. Winston which was never published.

This concludes the series.

Music Club News

by **MARK CRONSHAW**

Sketch by Dr. Bannister.

First of all, to review the 1978-1979 season of concerts: December saw two performances of Handel's *Messiah* in Southwark Cathedral. The combination of Peter Soothill's very able baton, superb soloists and a keen orchestra and choir drew near capacity audiences. This success was repeated on March 9th in the Greenwood Theatre in front of a large and enthusiastic audience. The programme included two Dvorak *Slavonic Dances* under the capable direction of David Melville, and Peter Soothill conducting Mozart's *Vesperae Solenes de Confessore,* a negro spiritual and Vivaldi's *Gloria.* All in all a memorable

concert, the delightful Tamsin Dives (soprano soloist) excelling herself, giving by popular demand an encore of the *Laudete pueri.*

A most successful season, both orchestra and choir being a definite improvement on recent years. Particular thanks must go to Andrew Tressider and Peter Soothill for their hard work in organising the last two concerts, and also to David Melville, co-conductor of the last concert, whose capable hand we are unfortunately losing to King's next year.

As for plans for the 1979-80 season: in the summer term it is intended to hold regular lunch time recitals in the chapel crypt, band concerts in the park and madrigal group singing again at lunch times. The Christmas concert will most likely be Mozart's *Requiem.*

At the moment under discussion is the possible formation of a regular meeting concert orchestra. The instrumentalists for such an orchestra are known to be present in Guy's, and if only they would be prepared to join an undreamt of standard could be achieved. I look forward to the day Guy's may perform a major piece such as Beethoven's *4th piano concerto*—we have the pianist and players of sufficiently high standard, so why not?

Anyone at all interested please contact the Music Club Committee through their East-Wing pigeon-hole.

Concert Review—March 9th, 1979.

An audience of well over 300 enjoyed an excellent rendering of Vivaldi's *Gloria* at the Greenwood Theatre. The concert began with the lively *Slavonic Dances* by Dvorak conducted by David Melville, which contrasted with the quiet, but moving, Mozart performed by the Guy's choir. The orchestra might have benefited from a stronger and more concerted violin section. This was followed by an energetic and enjoyable performance of *Go Down Moses* in which Ian Page was the impressive Baritone soloist.

The *Gloria* (which may not have been completely Vivaldi's own work) was the highlight of the evening; the choir directed expertly by Peter Soothill. There were five solos by Vernon Dunning (counter tenor) and Tamsin Dives (soprano) who also sang *"Laudate Dominum"* as an encore.

M.D.S.
R.J.S.

Films

Three cracking films that must not be missed have arrived just in time for those holiday evenings when you wish you were back at Guy's.

The Deerhunter is a modern classic with somewhat disturbing overtones. It is about the fortunes of three Americans who volunteer to fight in Vietnam. The fact that as non nationals they must have volunteered is not brought out in the film but is an important point. They are forced to

play Russian Roulette when captured by the Vietnamese and it is these scenes that are the most powerfully dramatic and frankly gut churning I have ever seen. The tension evoked by these scenes is fantastic and they are among the most gripping ever seen in the cinema. Hitchcock at his best was never like this.

Russian Roulette becomes an obsession throughout the film. Robert de Niro as one of the three volunteers, and the only one who survives the war in one piece, is superb. He comes back a hero but after all he has been through he cannot readjust to humdrum life, he cannot relate to his old friends and their activities and he is overcome by guilt at being the survivor. He returns to a war torn Saigon to find the third companion who has gone crazy and is playing Russian Roulette for high stakes in a Saigon bar. The climax to the film shook me to the core and I left the cinema feeling as if I'd been kicked in the stomach. This film will make the British backers (hurrah) very wealthy and it will make de Niro the most popular cinema artist of the next 5 years. If you see it, it will disturb you deeply, but you will marvel at its magnificence. When the film ended and the credits started to roll, instead of the usual flurry towards the exit, a stunned audience remained completely still and silent for several minutes—in itself a tribute to a brilliant film. See it.

The second is another excellent film. **Animal House** is an American film about college life and the sexy, boozy things that go on there. It is pure, not very clean fun and you will laugh all the way through. A college house enjoys wild parties, orgies and bouts of vandalism to such an extent that all concerned are expelled en masse. As revenge they destroy the end of term parade and generally break the place up. American college students are the same age as our University students and in many ways their outlook is very similar which is why I think all students should see Animal House. Who's going to have the first toga party?

Another film well worth a visit is **Boys from Brazil** adapted from Ira Levin's exciting book. The plot is rather complicated unless the genetics course is still lodged in your short term memory. All your favourite surviving Nazis are involved in a scheme to produce Hitlers by cloning, but it is Laurence Olivier who steals the show with an excellent performance as an ageing Nazi hunter. Whether Gregory Peck who gives a chilling performance as Mengele succeeds in his cloning plan or Olivier stops him I shall not reveal. The ending is dramatic and rather bloodthirsty but provides an exciting climax to a thrilling film. I suggest you enjoy your Easter holiday by seeing all three of these excellent films.

J.J.E.

Bob Peck writes :

By the time of printing this article one or two of the films reviewed may no longer be on in London, however, I feel that they are worth mentioning so that a look-out can be kept for them in case they return.

Probably one of the best films around at the moment is Carpenter's **Halloween.** John Carpenter has rapidly become one of the leading cult directors around today. His two previous films **Dark Star** and **Assault on Precinct 13** (both occasionally to be seen around London and well worth seeing) received much critical acclaim. The former is a zany

science-fiction film about an insane spaceship crew and their talking bombs. The latter is about a small ghetto battle against a police station. The attackers use high-velocity weapons with silencers attached, very effective in that one never knows when and from where the next shot will come. Back to Halloween, this is basically a scare movie. It is a supernatural tale, but a simple story of an everyday psychopath terrorising both the victims in the film and the audience in the cinema. It is brilliantly constructed and filmed, the music being an integral part of the tension building. I found it one of the most frightening films I have seen. Highly recommended.

Satyajit Ray is the best-known of Indian film-directors to Western audiences. He established his reputation with the **Apu Trilogy**, a trilogy of films about Bengali family life. His most recent film, **The Chess Players** (Academy, Oxford Street, £1.40 and £2.00) interrelates a game of chess between two rich Indian businessmen, neither of whose wives wish them to play at home, with the British taking over of the state in which they live. It is very beautifully filmed with a great attention to detail. It is also a highly amusing film with the two chess players using almost any means to play chess regardless of the situation.

Realm of the Senses, one of the most talked about films in recent years, for its explicit portrayal of sex and somewhat horrific ending in which the woman cuts off the man's penis, ensured that Nagisa Oshima's next film **Empire of Passion** (until recently at the Camden Plaza, £2.00) would receive much publicity. This was achieved, most of the notices being fairly praising of it. I cannot agree with them, however, as it reworked a theme used in many previous Japanese films—that of the wife and lover who kill the husband and are then haunted by the ghost of the dead man, and it also lacked the beauty of filming and direction that directors such as Mizoguchi have achieved. A slightly disappointing film although probably a good introduction to modern Japanese cinema.

Finally I must briefly mention **Mon Oncle** by and with Jacques Tati. A marvellously funny film in which anything that can go wrong—does. As in his other films **Monsieur Hulot's Holiday** and **Traffic** little dialogue is used and that that is used immediately tends to knock the person speaking. It shows how modern technology and the not-so-modern man come together and operate to nowhere near 100% efficiency. A classic film and, in my opinion, definitely worth making a journey to see.

Nursing

What are Nurses Worth?

The anarchy which has been demonstrated by many hospital employees is still successfully continuing to disrupt the services for which these people are responsible. One development however came as a welcome surprise for many and an unexpected shock for the government. This was the decision by an overwhelmingly large number of nurses to refrain from taking any industrial action.

From the reactions which have been shown by Mr. Ennals and his minions, this decision is one which is causing some disquiet within the corridors of power. Politicians do not, on the whole possess many scruples and have usually attained their positions by a mixture of deviousness and bullying. They are therefore, only able to contend with behaviour in others which equates to their own. Although they beseech the public to behave responsibly and with integrity, they are totally bemused when this happens.

The nurses have therefore, put the government in a quandary, for if they do not now receive satisfactory remuneration for their labours, every other group of workers in the country will react by resolving not to subject themselves to the same abuse. The problem of industrial unrest will then be compounded.

It is of course, true to say that because nurses are not a militant group, they tend to be underpaid; although the profession would have retained its esteem a little better, if those members who appear to have no appreciation of ethics, had not mounted such an unseemly display outside the House of Commons and the Department of Health in recent weeks. Many workers are insufficiently occupied and have therefore, time in which to become discontented. This is not true of nursing. The work is extremely demanding and usually very satisfying. As a result, those who practice it do not have much occasion to consider the injustices to which they are subjected.

It will be interesting to see the eventual outcome of the dilemma in which the government now finds itself. It will not wish to give adequate financial reward; and will do all in its power to avoid treating nurses any differently from the cleaners and porters whose work they frequently have to undertake in addition to their own. The cartoon which was published recently by one of the more reputable daily papers, portrayed accurately the attitude of not only the present minister but all his predecessors. It depicted the reaction of Mr. Ennals on hearing that the nurses proposed not to take action. He returned to the safe the money which he had planned to offer and stated that he need now only offer his sympathy, gratitude and respect to the profession. He sneered while he spoke the words! A cartoon maybe, but one containing much truth. One can only wonder how much longer the nurses will tolerate such treatment before reaching the limits of their endurance.

Pam Jefferies

Physiotherapy

Reference was made in last month's *Gazette* to the D.H.S.S. draft circular concerning the Department's favouring management of the remedial professions by district therapists. The February number of *Health and Trends* comments on the developing professional autonomy of physiotherapists. It is likely that most of us in Guy's would, if we thought about it at all, agree that this is the way the tide is running at present, and that benefit rather than harm is likely to accrue. It was, therefore, with something of a shock that one learned of the deliberations of a

group of doctors concerned with rehabilitation who constitute an E.E.C. advisory committee. This party, which includes British representatives, stated categorically that as far as its members are concerned the position vis à vis patient, doctor and therapist is in status quo, literally, ante bellum. In other words, the doctor prescribes the physiotherapy treatment with exactness and total authority, and the physiotherapist does as he/she is told, no more and no less.

Furthermore, the group affirm that for their money this situation will continue indefinitely, and that in effect they will have no truck with "physio-lib" in any of its manifestations.

Fortunately, the British representatives not only dissented from this retrogressive attitude but saw to it that they are recorded as having done so, dissociating themselves from their mainland European colleagues. But, while it is not clear who is the recipient of the advice of this group, it is at least disturbing to think that when the Europhysio bursts on the scene, she might be working within constraints that we have outgrown this many years.

Conflicting opinions abound as to the imminence or remoteness of any E.E.C. legislation which will affect remedial therapists. It is well-known that the processes which formulate policy of this kind are so slow-moving as to be virtually imperceptible, but there is also a disturbing sensation that what movement there is may escape the insular British eye, so that decisions are taken that are later difficult to resist. Not so, the optimists will say, and anyway there are years of negotiations ahead, assuming that anyone bothers to draw up regulations in the first place. But the prophets of doom can frighten us by pointing to happenings such as that outlined here, and by warning that this is advice that will be listened to, because it accords with European medical opinion.

Our present system of compulsory state-registration for N.H.S. therapists means that unrestricted movement between Common Market countries cannot take place. The C.P.S.M. Physiotherapists Register does not admit those trained in some countries at all, demands an extra period of clinical experience from others, and readily accepts still others. In other words, it is selective and aims to receive only those whose capabilities are on a par with our own. We are naturally concerned that, if there is to be a levelling, it will be up and not down, and fear the establishment of an unacceptably low common denominator if European doctors concerned with rehabilitation are influential in re-establishing a repressive control over our practices.

Ronald Cooper

Book Reviews

"Symptoms, Signs and Syndromes. A Medical Glossary", by B. Champney and F. G. Smiddy. Pp. 196. Price £1.95. Published by Baillière Tindall, 1979.

This book is aimed at the nurse and physiotherapist, its terms of reference virtually a glossary of symptoms, signs and syndromes, and as such it deserves some success. The style is clear and interesting, so its occasionally frustrating brevity may be redeemed by provoking the reader to further enquiry. The book covers most of the terms it should, although by strict exclusion of "diseases" one is left without definition of conditions such as Crohn's, Meniere's or hyperglycaemia, which is especially odd in a book that does include everyday syndromes such as Gradenigo's, Mendelson's and Waardenburg's! No doubt the authors would argue that it is the rare condition that *needs* a reference. One hopes that in the second edition some inaccuracies will be corrected and the cross-referencing improved. Rheumatoid goes unlisted in major causes of arthritis; the three most common causes of amenorrhoea are omitted from the relevant section; entries on acetonuria, ketonuria and ketoacidosis appear as quite separate entities, for example. A good book for the ward library, but probably even better next time round.

B. H. HICKS.
Clinical Tutor.

"HELP! First Aid for Everyday Emergencies", by N. Bezzant, A. G. R. Bone, E. C. Dawson and C. Shelton. Pp. 126. Price 95p. Published by Collins, 1978.

This paperback on first-aid for everyday emergencies has been written for members of the general public by experts of the St. John Ambulance Brigade.

Early sections deal with prevention of accidents and assembling a first-aid kit for the home. These are followed by clear descriptions of well-tried procedures illustrated by line drawings.

Emphasis is placed on priorities and anyone reading the book with care will learn useful approaches to the art of managing the emergency situation.

Doctors can read it with profit to learn essential first-aid and to obtain a sound text for teaching first-aid classes.

More lives could be saved if more people knew some first-aid such as the use of the recovery position for the unconscious patient.

Here is a suitable subject for teaching by film and television, especially in short interludes: and here is a good text for the programmes.

Major-General N. C. ROGERS,
Clinical Superintendent.

"Vascular Trauma" (Eds. Norman M. Rich and Frank C. Spencer). Pp. 610. Price £27.00. Published by Saunders, 1978.

This 600 page book with copious illustrations including succinct line drawings in addition to well produced X-rays and photographs (often taken under difficult conditions) is edited by two of the world's leading authorities on vascular injuries. The text is based on a retrospective study of the methods and results of treatment of arterial and venous injuries encountered by some 600 American surgeons whose experiences were recorded in the Vietnam Vascular Registry and covers the years 1965–1972. Subsequent treatment, where appropriate, mainly performed at the Walter Reed Army Medical Center, Washington D.C. is also included.

The wealth of clinical material presented, of course, directly relates to the magnitude of the conflict in South East Asia during the period concerned, although experiences seem remarkably similar to those encountered recently in such centres as Dallas and St. Louis, frequently cited amongst others in the book as examples of civilian vascular trauma environments. These circumstances seem far removed from the relatively peaceful conditions in the vicinity of most British hospitals but the basic principles gleaned from this enormous experience are invaluable in dealing with trauma patients in any Casualty Department.

The high index of suspicion necessary for the prompt detection of vascular lesions associated with penetrating or blunt trauma is well conveyed in a chapter on clinical evaluation of vascular trauma which follows three introductory chapters on the history, aetiology and clinical pathology of vascular injuries as well as recent research developments. The

following six chapters deal with management and sequelae of arterial trauma as well as associated venous, nervous and bony injuries and serve, again, as a lively reminder of the need to be aware of vascular lesions in the patient with an apparently uncomplicated soft tissue or bony injury. Chapters 11 to 25 deal with the presentation, diagnosis and management of specific arterial injuries and cover most forseeable clinical problems. Complications of invasive intravascular procedures such as central venous catheterisation and angiographic procedures, not uncommonly disregarded through unfamiliarity, are well described in appropriate sections.

Although primarily a book produced by experts for the edification of the few who are likely to meet these testing and often life or limb-threatening injuries it is, nevertheless, a volume that should be available to all those involved with trauma however pedestrian. The book is well worth its place on any medical library shelf and certain sections should be required reading for all surgeons involved in the vascular assessment or management of the injured patient.

I. McCOLL,
Professor, Dept. Surgery

"An Introduction to Fixed Appliances. Dental Practitioner Handbook No. 17", 2nd edition, by Isaacson and Williams. Pp. 162. Price £6. Published by John Wright & Sons Ltd.

The first edition of this book was of immediate value to all postgraduate orthodontic students and of obvious benefit to those interested dental practitioners wishing to improve or update their systems of orthodontic treatment. This second edition increases the usefulness of the text well beyond the addition of some forty-four pages. New short sections on the Scope of Fixed Appliances, Supervision of the Patient, The Development of Fixed Appliances and Advanced Techniques, have been added and many of the original chapters extended and reorganised. The change to a paper that does not reflect the light and the new style of print have improved the readability, while many of the illustrations now occupy clearer positions on their page.

The authors describe many of the well accepted fixed appliance techniques that they employ. The principles of the system are clearly discussed and compared to alternative treatment options. No attempt is made to consider the diagnosis of orthodontic patients since correctly this has to be left to other types of text-book.

The book is successfully aimed at helping graduates who are being prepared for the Diploma in Orthodontics, though anyone considering modern orthodontic treatment will find much to interest and instruct.

LAURENCE USISKIN,
Senior Lecturer, Dept. Orthodontics.

"An Atlas of Otolaryngologic Radiology", by J. Zizmov and A. M. Noyek. Pp. 497. Price £24.50. Published by Saunders, 1978.

This atlas, compiled by a radiologist, an otolaryngologist, and assisted by two neuroradiologists, is comprehensive. Nearly 500 patients are illustrated, with multiple views. The range of conditions shown is unlikely to be exceeded in the lifetime of any clinician in this field.

The captions are good but details of normal examinations are not given. This is reasonable in this kind of work although tomography of the temporal bones might have benefited from accompanying line drawings. It is notoriously difficult to reproduce views of these structures owing to the poor contrast given by meagre air containing cavities and a good deal of experience is required for comprehension.

With this mild proviso the standard of the illustrations is superb and the size and space given is generous. An attempt has been made to show the various modalities of use in this field and these include radio-nucleotides, ultrasound, thermography, xerography and C.T. scans in addition to general radiography. It is certainly interesting to compare the information obtained by these means although the reviewer doubts the value of, for example, thermography in sinus disease. In particular the place of C.T. scanning in E.N.T. work remains to be fully assessed but its value is not in question. The transverse sonograms of the neck seem very useful.

The range covered is somewhat wider than we would consider usually encompassed by the title. Thus dental tumours are included and there are sections on the bronchi and oesophagus.

To sum up this is a valuable work which could well find a place in all relevant departmental libraries. Furthermore it would undoubtedly repay study by radiologists and E.N.T. surgeons of all grades but it does presuppose a good knowledge of the subject obtained from other sources. Text book detail has been deliberately omitted in order to provide ready reference on a given case. The authors are to be congratulated.

E. O. L. HOSKINS.
Dept. Diagnostic Radiology.

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ROYAL NAVY DENTAL CADETSHIP

Correspondence

Radio Guy's

Sir,

I had the privilege of being present on Tuesday, 6th March, 1979, when Radio Guy's resumed broadcasting after being off the air for twenty months.

The re-opening ceremony was performed by David Jacobs, the well-known B.B.C. broadcaster, in his usual impeccable manner.

Radio Guy's now occupies a splendid new studio with most modern equipment. However, what impressed me most was the enthusiasm of the willing band of workers, who render this invaluable service to the patients in a completely voluntary capacity and without any reward other than the satisfaction of a job well done.

Through the medium of your pages I would like to pay tribute to this splendid group of young men who comprise Radio Guy's and who give so much pleasure to the patients. Long may they flourish!

Yours faithfully,

LYDIA FRANKS.

9 Fairacres,
Roehampton Lane,
Roehampton, SW15 5LX.

Rugby Memories

I have just read the Rugby Club record of the early twenties—they were indeed glorious days—and although my highest achievement was for one season to play in the "A" XV when we won the Junior Hospital Cup, I knew all these great people very well indeed.

One of my patients, now dead, told me that a London Hospital man went from his front line quarters in France in the 1914–18 War to visit the South Africans, and he came back very disgusted and said they were all going to Guy's!

I think that when I played for the "A" XV one or more other scrum-halves were crocked.

Yours sincerely,

GEORGE WESTON.

115 Parkanaur Avenue,
Thorpe Bay,
Essex.

Panel of Translators

Sir,

May the Wills Library ask once again whether any of your readers who have a knowledge of a foreign language would be prepared to act as interpreters for patients or undertake short, informal translations of letters or papers. The Library maintains a list of the staff and students who are willing to help in this way; their assistance is much appreciated, especially by patients who have no English. A new, updated list is in preparation, and anyone willing to appear on it should please contact the Wills Library.

J. M. FARMER.

Wills Librarian,
Guy's Hospital Medical School,
SE1 9RT.

The Snowflake Ball

Sir,

There are several points about the most recent Snowflake Ball, which I feel need some explanation from the organisers of this aforementioned fiasco. I hope that their reply will not be the usual load of flatulence that one so often gets for an explanation.

1. Why did the No. 1 billing "Top Comedian" not turn up?

2. Why did the Steel Band (who I believe turned up) not play?

3. Why were the advertised films not shown?

4. Who was the idiot on the dinner room door and why was he telling everybody dinner was running threequarters of an hour late, only for me to push my way in and find that the other people on my table had started and, in fact, finished their first course?

5. Where is the refund of the money that was to be paid to the artistes that did not turn up?

6. Why has not an explanation of these matters been VOLUNTARILY forthcoming from the organisers?

Yours,

an enjoyer of Snowflake Balls in previous years,

R. J. PECK.

c/o Boland House,
Guy's Hospital, SE1 9RT.

Sir,

My father, Mr. Bill Maskell, worked at Guy's Hospital for 15 years in the Dental Department and in the residence wing when it was completed until the time he left England to take up residence in Australia.

For those doctors and dentists who remember him, as well as dental nurses, and anyone in that department, I wish to inform them that he passed away on January 4th, 1976, followed closely by his wife Sylvia on October 18th, 1976.

He was a man well respected in the hospital, as I well know, as I worked there for five years myself, and although three years ago now, his loss and that of my mother has left a hole that no-one can fill.

Wishing all the best to the continued success of the *Gazette*.

I remain,

Yours truly,

W. E. MASKELL.

26 Janice Street,
Gailes 4300,
Queensland,
Australia.

Sir,

I would like to congratulate the Dental Society Management Committee on a most enjoyable evening at the Grosvenor House Ballroom during the Dental Dinner and Ball. However, I felt there was one sad omission during the evening's events; namely, the Annual Report by the Secretary. The highlight, during my term of office 1976 to 1977, was undoubtedly the speech, and I feel that successive Secretaries should have the honour of post-prandial speakings at this traditional function. Indeed, the audience look forward to what is the shortest and last speech of the evening!

I have no recollection of any decision by the Committee to drop the Annual Report, though we instigated the combined Dinner and Ball for economic reasons. I hope this will be rectified at future dinners.

Yours faithfully,

A. MILOSEVIC.

Liverpool Dental Hospital,
Pembroke Place,
Liverpool, L3 5PS.

Back Numbers

Sir,

Whilst clearing out some old boxes of books I came across four bound volumes of *Guy's Hospital Gazette*, each of 500–600 pages, in good condition, and dated 1921, 1922, 1923 and 1924.

If they are of any interest to you or anyone else at the hospital I should be happy to let you have them.

Yours sincerely,

A. T. COLBECK.

"Fountains",
Kingston St. Mary,
Taunton,
Somerset, TA2 8HW.

The War Memorial Arch

Sir,

When I wrote to you in December (*Gazette*, 27th January), I was an Inpatient and had not seen the current number so that I was not aware that Mr. Cann had referred to the Arch in an article and that a photograph had been printed. The present generation are incredulous of the absence of financial reward for Residents in the pre-war years; the privilege of a House Appointment at Guy's was at that time considered sufficient reward. The return of the Memorial Arch might serve to remind us of the past service given by Guy's men to the Hospital and the country that has made possible conditions of today.

I have read with interest the letters of Dr. Philip Helliwell and Dr. George Weston in the *Gazette* (24th February). Dr. Weston's brother who went down with the Rawalpindi was, I think, the first Guy's man lost in the '39–'45 War.

I and many others would gladly contribute to a Restoration Fund suggested by Dr. Helliwell, but the Guy's Special Trustees still exist (and could not be subservient to the N.H.S.), and they might consider this project worthy of their support. In any case, I agree that an estimate for the restoration should be obtained as a matter of urgency.

I am, Sir,

Yours etc.,

DAVID ERSKINE.

"Sutton Rise",
Ogmore-by-Sea, CF32 0PE,
Mid-Glamorgan.

Sport

BORE IN AMERICA
SPORTS REPORT

Well here it is at last, the long awaited Bore exposé of sport in America. I was in America for two months over Xmas and although winter is the close season for many of America's sporting spectacles such as baseball and more recently soccer there was plenty to witness and admire about their sporting scene.

The first thing I found about the Americans was that they are neurotic about their fitness, practically all young men and many young women take part in some sporting activity. The most popular exercise is a quick jog at the weekend taken almost to extremes by the fitness crazy Americans. I went for a walk in Central Park, New York at ten one Sunday morning and saw teeming hordes of joggers puffing and wheezing through the park. In Central Park there are also hundreds of squirrels and I could have had a wonderful morning taking alternate pot shots at joggers and squirrels. The joggers were a delight to watch—fat, thin, tall, short, fast or very slow, asthmatic or rheumatic—a marvellous spectacle.

It is very apparent that this awareness and keenness concerning sports and health leads to Americans having much better body builds than we weedy Europeans. They have in very general terms much broader and thicker builds. I suppose this is partly genetic but must also reflect the increased part sport plays in the education of the young American. Where can you find six foot seven inch Englishmen? In the States they make up a population of people who play basketball. Basketball is very popular at College, University and professional levels. It is also popular on the television although I never felt it made a very good spectator sport unless you were there, live.

I went to see a University basketball game which was quite something. West Virginia University has a 20,000-seater stadium just for basketball. The razamataz involved in the sport is more of a spectacle than the game itself. Each team has its own brass band sitting on the front rows equipped with five or six drummers and a chap on tom-toms. The home team has a slightly larger band of course. The band play jungle rhythms and victory tunes and during time-outs a bunch of lady acrobats perform rather tedious acrobatics. The home team has a mascot who is dressed in West Virginia buckskins and runs round the stadium shooting his gun after every good play and frightening the hell out of one particular part of the audience—me.

The brass bands were very impressive but I thought it was rather unsporting that if the opposition had two free shots the home side's drummers would beat loud drum rolls to put him off. The enormous crowd went beserk at every exciting move and whenever the home side scored, and the basketball coach was in a frenzy tearing at his hair as if his life depended on the game (which it probably did). I thought it was all rather over the top but thoroughly enjoyed it. I later saw a High School game which was pretty similar but I am sure most of the crowd was there to watch the fifteen-year-old cheer leaders who were very decorative to say the least.

I was actually allowed to participate in one sport only as the Americans seemed to have their teams pretty full up, whilst I was there. I played soccer with some surgeons who told me they were pretty good. They thought they were so good that they had challenged the main University to a match. They even flew their star centre-forward from his new job in Argentina to play. Twelve players assembled for the game but the University fielded 33 players, played the game in three half-hour segments and substituted their entire team at the end of each segment. The surgeons lost eleven-nil.

I encouraged an American friend, Ned, to play soccer with these surgeons and myself. When we arrived I was showing them the English rocket shot and nearly killed one of the surgeon's small children with a slight miskick. At the other end I was showing them the English bullet header when the ball went over the top of the fence, bounced once in the dual carriageway and rolled down the hill into the river. Not an auspicious start. However, the pitch was usually used for American football and when they took conversions after a touch down someone had to stand on the river bank

to try and catch the ball before it bounced into the river. Ned said he thought it was a game for English pooftahs as there wasn't enough physical contact. He did a lot of damage to the legs of a slow but fancy Argentinian who thought he could put the ball through Ned's legs. Norman Hunter would have looked mild by comparison.

I also watched a College five-a-side soccer game which had a few useful ideas. For example it would be a good idea to have two referees instead of one to help control some of these angry English, professional games. However, basically American soccer is a long way behind English soccer. The English are so much more aggressive and tough in their game whereas Americans moan after every hard tackle and their tactics are naive and elementary. Of course soccer will never be very popular in America because there are no time-outs for the adverts on the television.

America's biggest winter sport is American football which is an aggressive form of Rugby played with no offsides. I must make clear that this is a fine game to watch but not, I repeat not, to play unless you collect fractures as a hobby. On a Sunday in the States football on the television starts at 1 o'clock and finishes at 9 in the evening. One of the best ways of spending time there is to lie on the settee with a six pack of beer handy and watch hours of American football. I was lucky enough to see the Superbowl which is the equivalent of the F.A. Cup Final. This was a superb game watched by half the country and the Pittsburg Pirates murdered the Dallas Cowboys. The pre-match analysis on television started a whole two days before the Superbowl. The highlight of a day's football is the tackle of the week. A typical tackle would happen to a player who jumps for a ball and before he returns to the ground he is hit by three of the opposition at once. Bone shaking. Surely Jimmy Hill could find a soccer tackle of the week.

Lastly a game which is on the increase in America is Backgammon. This excellent game for the more sedentary is becoming much more popular. I spent many happy hours playing Backgammon in American bars, drinking their nasty fizzy lager.

So I enjoyed watching American sport —their television coverage is excellent (the only good thing about American television), but I think with my English build neither American football nor Basketball were for me. Apparently Rugby is becoming popular but it is rather dangerous because Americans play it as if they were playing American football but they don't wear protective gear. However, I'm glad to say we're much better at soccer than they are so all is not hopeless and I'm pleased to be home.

BORE.

RUGBY

GUTTERIDGE PLATE COMPETITION—FINAL

Guy's 9 pts., Imperial College 21 pts.
Wednesday, 28th February, 1979

Guy's Freshers did very well to reach the final of this competition which was played at Motspur Park. Having reached the final it was decided to leave the team basically unchanged which put us at a disadvantage against a strong Imperial College side.

Guy's took the lead with a beautifully worked move beginning with an inside break by the captain, Steve Kennedy and ending with Mike Hackett scoring underneath the post and also converting the try. Imperial College quickly levelled the score, with a try and conversion, taking advantage of a defensive mix-up by Guy's, and then went ahead with a penalty before half-time.

In the second half Imperial College began to dominate the game, especially in the scrum, scoring two more trys and were unlucky not to score another. Mike Hackett pulled back 3 points with a late penalty. However this was a creditable performance from a freshers' side which bodes well for the future of Guy's Rugby.

Team: Parry, Langton, Kennedy (Captain), Beard, Edwards, Flannagan, Liddell, Girling, Wyeth, Hackett, Williams, Cox, Rudiak, Maggs, Manning.

J. B.

GUY'S 12 pts., NUNEATON 19 pts.
Saturday, 10th March, 1979

As usual this was a closely contested game; Guy's with two recent wins behind them being eager to avenge their narrow defeat at Nuneaton last year.

Guy's began well and were unlucky to go three points down to a surprise drop-goal by Nuneaton. However Guy's quickly went into the lead with probably their best try of the season scored by the ever-improving winger Hugh Williams who ran a full fifty yards, kicking over the full-back's head, to score a spectacular try which was converted by Mike

Hackett. Guy's went further ahead with a penalty by Mike Hackett but Nuneaton scored a try in the corner from a scrummage almost on the Guy's line.

In the second half, Guy's went further ahead with another penalty by Mike Hackett who's kicking throughout the game was of great encouragement to the rest of the team. Nuneaton went ahead with two quick penalties in succession from offside infringements by Guy's and then scored a push-over try after a period of intense pressure on the Guy's line.

The forwards did well against a heavy Nuneaton Pack especially in the line-out. This may have been due to the new arrangement of Jeremy Gray and Jon Beard in the second row and Brian Keevil at number eight. Richard Laws at scrum-half also made good use of the ball made available to him by the forwards.

Team: Parry (Captain), Gibson, Neill, Beard, Gray, Brazier, Flannagan, Keevil, Laws, Hackett, Portelly, Francis, Wilkinson, Williams, Manning.

J. B.

SOCCER

1st XI REPORT

Guy's 1st XI staggered back from Christmas with a great deal of work to do having picked up only three points in the first half of the season in this very competitive Premier Division. Although it was thought that we had been somewhat unlucky not to have at the very least double this number of points.

Several hard games after the break yielded only one point, away to the London our most bitter rivals. In a hard fought game which could have gone either way, Guy's at last regained some face against this club that has in the past cheated us of victory by both fair and foul means.

Even after this morale booster points were still hard to come by, and in the following weeks team selection became a real problem. My thanks are due to Geoff Pigot and John Pascoe for filling in when so-called footballers were not keen to do so. Also mention must be made of Gary Calver and Graeme Smith who were prepared to put themselves out and return from their regional appointments to play when other players nearer home did not make the effort. They both filled in many times never once letting any team down.

With relegation looming, particularly after another depressing defeat by Royal Free, which we never looked like saving inspite of the fact that victory would have made our position safe. Since then eight points have been added with double fixtures against Royal Holloway and U.C., but it seems as if we must wait for next term to decide the relegation issue as the weather again made playing of final fixtures impossible.

SIMON PERKINS.

3rd XI REPORT

Steven Robinson's ever-present boil kept him out of the side for the first time this season. Chaotic team changes resulting in a new-look Guy's IIIrds. They ran out easy winners against an excellent Kings College Hospital side, by 8—5. Vice-captain "Bum" Bond scoring twice.

The return of Skipper Steve Grumitt Robeson in the following game against Middlesex IInds heralded a return to losing form, mistakes by Steve resulting in two of Middlesex's three goals, Guy's replying once.

After an excellent start to his debut season at Guy's Doug Miller could not find a lorry big enough to carry all his different boots and lost interest.

John Exelby has also had an excellent season, improving all the time with pugnacious performances and has slipped in a couple of good goals, and has constantly been piling on the pressure in midfield.

More recent results have been more encouraging including a 5—0 thrashing of Westminster II in which Skipper S. Nigel Robbins did not play, and a 5—3 victory against St. Thomas's II which Steve did not play either.

Nigel's return was marked by a 6—0 defeat by K.C.H. III. Optimism returned when we played UCH IInds—the top team of the league—away from home. Skipper Steve hobbled through the first half with a leg injury and at half time Guy's were 0—3 down. Steve was taken off and Guy's came back to 3—3 with only ten men. Club Doctor Mary Hodgkinson said that Steve's injury was probably "Blood on the Knee".

So on the whole a fairly successful opening season for Guy's III. All in all 37 different people have played for the IIIrds. Table: P 20, W 7, D 4, L 8, F 52, A 60, Pts. 18, Pos. 5th.

So our thanks to all especially Skipper and Captain Steve Robeson and we wish to extend him our best wishes.

ALF "SNIFFER" STYLES.

U.H. CUP SEMI-FINAL REPLAY

Guy's II 4, Charing Cross II 2

We all trekked down to HOP
The semi-final of the UH Cup,
We hoped that after this game
Many pints of beer we'd sup.
Before the match we kick around
and laugh at Greenaway,
If he'd scored in the previous match
There wouldn't have been a replay.
The whistle blew and Guy's boys ran
Under orders from Roger and Harri,
While from the sideline shouted
Seb Johnson and Gratton Parry.
Alas fear struck when Charing Cross
Scored to put them in the lead,
Prof. Robinson from the sideline shouted
"Chaps, take heed indeed!"
Keith Underwood equalised
With a scorcher into the net,
Charing Cross supporters
May just lose their bet.
But undeterred Cross scored again
A little from the right,
Guy's however refused to
Give up their gruesome fight.
John Rawcliffe swerves a corner
We realise,
And Roger Davies heads it home
to equalise.
The second half started with
Guy's the better team,
The midfield looking sharp
The defence looking mean.
We held them off attacked in force
And settled in their half,
Jon Earnshaw scores a rocketing shot
On straight and narrow path.
Guy's are winning 4—2 up
When the final whistle goes,
Captain Davies had scored the bitter
fourth
that froze the Charing Cross toes.
The bar was lively and beer was drunk
What a lovely taste,
But who would willingly compete
In a cold baked bean boat race?
We're gonna win the Cup!

KEITH.

GUY'S II 3, L.S.E. III 1

In this game, played at Honor Oak Park, Guy's were able to field their likely Cup Final side for the first time since their Semi-final victory over Charing Cross.

Guy's started in fine style with the midfield finding a good understanding and the defence holding firm. They were soon rewarded with a goal from a well worked corner and Dave Greenaway headed in at the far post. This goal heralded a period of fast open football, putting intense pressure on the visitors' goal. A second goal was inevitable and this was provided after 20 minutes when Jon Earnshaw gained possession on the edge of the penalty area and shot home under the despairing goalkeeper. John Rawcliffe soon scored a third with a fine left-foot shot.

Half-time arrived wtih Guy's holding a comfortable 3—0 lead and the oranges were sucked with a thirst, Guy's hoping to run up a cricket score.

However, L.S.E. must have had a half-time roasting from Brian Clough, for they came out looking much more determined.

Guy's made it easier for L.S.E. by sitting on their laurels, and they were lucky not to concede a couple of goals. With 15 minutes left Guy's gallant Captain Roger Davies went down injured and had to go off.

This resulted in some quick reorganisation, but L.S.E. doubled their efforts and scored a deserved goal soon after. The last 10 minutes were spent almost entirely in Guy's penalty area but the 10 men held on without further alarms.

At the time of going to press, the Cup Final will have been played and if Guy's maintain the standard produced in the first half-hour, the Cup should now be gleaming in the Trophy Cupboard.

Team: N. Cowland, H. Williams, M. Batterbury, R. Trembath, D. Abraham, R. Davies, D. Greenaway, A. Williams, K. Underwood, J. Earnshaw, J. Rawcliffe.

HOCKEY

On 29th of February Guy's beat Reads 2—1 which earned us two points and meant that we had won the third division of the Kent League without dropping a point. This is no mean feat and the whole side deserves credit for this achievement.

Before Christmas it had been fairly plain sailing and Guy's defeated most opposition with very little difficulty. We scored a total of 22 goals with five against. However after Christmas things became harder. The weather deteriorated leaving us short of practice and as a consequence our play lost some of its sharpness and became decidedly ragged at times. However we struggled through to beat Faversham, I.P.M. and Reads and maintain our 100 per cent record.

Besides the success in the league two other games stand out. One was against the Old Beckenhamians who were at the time of the match two points clear of the first division. This was in the second round of the Kent Cup and it developed into a classic cup-tie with Guy's attempt-

ing a giant killing act. We eventually lost 2—0 (two short corners) but this was after putting the opposition under severe pressure for much of the game. Had we been sharper near the goal it could have been a different story. The other game was against Tulse Hill 2nd XI. We lost 5—1 mainly because we ran out of steam in the second half but considering Tulse Hill are a London League side it was a spirited display.

Both these games underline the fact that the club must not rest on its haunches next year. We must start winning these sort of games if we are to compete in Division II and the Hospitals Cup next year. To do this will require all players to put in a lot of effort for fitness and skills. Hopefully the authorities that be will smile on us again and provide us with some more players to help those who played this year. As all the current 1st XI will be with us again next season things look quite encouraging at present.

Of those players Pascoe, Hett, Jones and Saward all represented United Hospitals at some stage during the season and Plowman who was the top goal scorer and Wyeth also made vital contributions to our success this year. Congratulations to them and the rest of the side for their efforts and good luck at the Folkestone Hockey Festival.

Team from: Pascoe, Saward, Holmes, Harris, Gulamali, Sanders, Hett, Forber, Singh, Barras, Karim, Jones, Wyeth, Plowman.

WATER POLO

Guy's are at present having one of their best seasons for many years. Having won the U.L.U. water polo knock-out competition before Christmas they were determined to do well in the U.L.U. League this season. Unfortunately Guy's started the beginning of the league minus regular goalkeeper, Jon Beard, who was still sunning himself on his elective in Barbados, and so lost two early matches which they might have won. The team improved with every match under the captaincy of Dave Rickard finishing in third place behind Bart's and The London.

Mark and Ray Vella from Malta have proved a great asset to the side and Mike Evans, Greg Wilcox and Pete Robinson have all improved this season providing the basis of a strong team for several years to come.

Results:

Guy's v. London: 4—5.
Guy's v. Royal Free: 7—2.
Guy's v. Bart's: 1—3 and 4—5.
Guy's v. Imperial College: 7—3 and 8—2.
Guy's v. University College: 3—6 and 6—3.

Team: Dave Rickard (Captain), Mike Miller, Jon Beard, Mike Evans, Gabriel Teo, Mark Vella, Ray Vella, Greg Wilcox, and last but not least, Pete Robinson.

J. B.

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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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GUY'S HOSPITAL,
LONDON, S.E.1.

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28 APRIL 1979 VOLUME 94 NUMBER 2291

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Passim

Give to Caesar what is Caesar's

The hospital administrators have apparently decided to transfer Guy's archives to the Public Records Office in Central London, far from the attentions of our hospital archivist, and the great institution which produced them. We feel that this is an unnecessary and damaging move which may be legally, and is certainly morally indefensible and which the Medical School should oppose.

We would be the first to admit that the archives belong to the nation, but foremost, they are the property of Guy's, and represent our history, or such scraps of it as survive. If such a gigantic and impersonal conglomerate as Guy's Health District can be said to have a heart, it must surely be at Guy's—in the records; for here is detailed the birth, childhood and stormy adolescence of the place, and reminders of the men on whom its world wide reputation was founded. Today's bureaucrats plan to tear out the heart and guts and replace them with sawdust.

If the concern is to provide space—for more files no doubt—the *Gazette* will gladly accommodate as much of the material as possible and we are sure that the Medical School can find a home for the rest. For these archives are *not* at the disposal of the N.H.S. because much of the material is the property of the Medical School, who should have their say in its disposal. There is little doubt that they will share our view—Give to Caesar what is Caesar's.

Defenders of this wretched scheme point out that most of the major London hospitals have already transferred their records, but we hold that this is an excellent reason for keeping those we have. This hospital employs an archivist, Mr. T. H. E. Orde, and when he retires there will be no shortage of applicants for the post; of course, we shall probably hear quite soon that the Archivist will not be replaced. Whoever heard of an archivist without archives? We are assured of public access to the archives in their new home, but there is public access at Guy's anyway, and interested scholars can inspect the hospital at the same time. We believe that this hospital is enriched by the thoughtful preservation and *elucidation* of its history, and will be diminished by its loss.

Guy's Hospital Gazette

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: 14th May and 18th June, 1979.

Copy may be sent to us at 16 St. Thomas Street, SE1 9RT.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (prepaid, minimum £2.00).

Non-subscribers are charged £2.00 (prepaid) for all notices other than Death.

News in Brief

Double win for Guy's Men

Readers will be interested to note that both the Barclay Medal and Barclay Prize from the British Institute of Radiology went to Guy's men. Dr. I. Kelsey Fry, D.M., F.R.C.P., F.R.C.R., now at St. Bartholomew's Hospital, was awarded the Barclay Medal for outstanding contributions to the understanding of the action of contrast media in the human body. Professor B. J. Cremin, F.R.A.C.R., of Groote Schuur Hospital, South Africa won the Barclay Prize for many valuable contributions to the *British Journal of Radiology,* particularly in the field of paediatric radiology. This must be a unique double to be achieved in the same year and our congratulations go to the distinguished recipients.

New Nursing Journal

Our congratulations to Dr. William Jackson, a Guy's man and Medical Editorial Director of *Medicine,* on the launching this month of *Nursing,* a sister journal following the same add-on format. The new journal describes itself as the first devoted in its entirety to clinical nursing, its performance and problems. We wish Dr. Jackson well with this new venture.

Guy's Squash Victory

Our heartiest congratulations to the winners of the Inter-Hospitals Cup Competition who beat St. Mary's 3–2 in the final recently. The team was J. Farquharson (Captain), R. Lewis, R. Sharp, D. Webber and C. Holden. A full report and team photograph will be found in the Sports section.

In place of strife . . .

We apologise to our subscribers for the very delayed arrival of the March *Gazette.* This was caused by industrial inaction on the part of postal workers in the Orpington and Bromley areas, which affected our printing and distribution.

Dates from the Medical Diary

May

Mon. 7 Bank Holiday. Medical School Office closed.
Mon. 21 Entries close for the Final Conjoint Examination in June.
Mon. 28 Bank Holiday. Medical School Office closed.

Dates from the Dental Diary

May

Mon. 7 Bank Holiday. Medical School Office closed.
Mon. 14 Final L.D.S. Examination, Part I begins.
Fri. 18 Entries close for the David Frank Sturdee Prize in Prosthetic Dentistry and the Properties of Dental Materials.
Mon. 21 First L.D.S. Examination begins.
Mon. 28 Bank Holiday. Medical School Office closed.
Tues. 29 Final L.D.S. Examination, Part III begins.

Thur. 31 The Malleson Prize for Dental Students' Research—reports must be submitted not later than this date.

New lectureship in Paediatric Nephrology

Thanks to the efforts of Dr. C. Chantler, a benefaction of £50,000 has been received from the British Kidney Patients' Association to constitute half of a fund to support a Lecturer in Paediatric Nephrology at the School, to be known as the British Kidney Patients' Association Lectureship in Paediatric Nephrology.

Other gifts to this fund include £10,000 each from the *Daily Mirror* and the Children's Renal Fund and £2,400 from the National Kidney Research Fund. The last of these gifts was subscribed by readers of the *Sunday People* as the result of an appeal by Mr. Ray Nunn, "Man of the People". The remainder of the £100,000 fund is still being raised.

Squash Courts

The four squash courts on the Weston Street side of the Guy's site are open as follows:—

Mon.-Fri.	08.20 - 22.00	Charges: 50p per 40 minutes
Sat., Sun.	09.00 - 18.00	payable into light meter

Anyone wishing to use the courts must be a fully paid-up member of the Squash Section of the Staff Club. Membership application forms are available in the swimming-pool office and in the squash courts.

Courts may be booked between:—
Mon.-Fri. 11.00 - 20.00
Sat., Sun. No booking

At present, bookings may be made in person at the Orchard-Lisle swimming pool, or by telephone (ext. 3259). Within the next fortnight, however, a telephone will be installed in the squash courts, and bookings will then be handled only at this location.

Until the telephone is installed, the present key deposit system will be continued for access to the courts. After installation, the door will be left open from 11.00 a.m.-8.00 p.m., with staff on duty inside.

Before 11.00 a.m., after 8.00 p.m., and at weekends, access to the courts may be gained by obtaining a key from reception in the Nurses Homes, on personal signature and deposit of £1.00, refundable upon return. No bookings will be taken by staff in the Nurses Home, so it is up to individual players to book courts well in advance to avoid confusion, and possible disappointment.

It must be emphasised that the above system may exist for a trial period only. If the facilities are abused in any way, opening times and staffing arrangements will be reviewed with a view to restricting hours.

Tennis Courts

The new tennis courts on the Weston Street side of Guy's site are now open to use. There are two courts with adjacent changing facilities in the Squash Courts. Opening times are as follows:—

08.00 - Sunset Sunday - Saturday

Nets will be taken down on 31 October and replaced on 1 March.

At present bookings may be made in person or by telephone at the

Orchard-Lisle swimming pool (ext. 3259). However, as soon as a telephone is installed in the Squash Courts, all bookings will be handled at this location.

Each session will last 1 hour, and the courts are available, free, to all paid-up members of Guy's Hospital Staff Club. Court bookings must be cancelled 24 hours before the proposed time of use to prevent inconvenience to other players.

Players who wish to use the changing-rooms in the Squash Courts, before 11.00 a.m., after 8.00 p.m. or at weekends can obtain a key from reception in the Nurses Home, on personal signature and deposit of £1. No bookings will be taken by staff in the Nurses Home, so it is up to individual players to book courts well in advance to avoid confusion and possible disappointment.

It must be emphasised that if the squash courts changing rooms are abused in any way, this facility is likely to be withdrawn.

Suitable equipment should be used and proper clothing worn at all times.

Obituary

DAVID PAUL ADAMSON, M.B.E.

On March 6th a remarkable life and a veritable medical odyssey came to a premature end in Hamilton, Ontario.

David was born in Scotland and went to school in London. In 1939 he joined the Fleet Air Arm and served as fighter and later test pilot. Altogether he flew 54 different types of aircraft amongst which figures the Gladiator *Faith* of Malta fame. He was awarded the M.B.E. in the 1946 New Year's Honours.

On demobilisation he was able to realise his early ambition to become a doctor and came to Guy's where he qualified in 1952. He spent a year in general practice in South Wales before emigrating to South Africa.

He was an orthopaedic registrar in Durban and on his return to the U.K. went to the Royal Sussex County Hospital in the same capacity and later became a neurosurgical registrar at the Haywards Heath Centre.

In due course he emigrated to Australia where he spent some time in the Royal Australian Air Force before going into practice in a small town in Victoria.

After a time he was attracted by an aviation medicine post in the U.K. which he took up and later left for general practice in Reading.

In 1965 he made his final move, this time to Canada where he went into general practice in Hamilton.

His final illness was fortunately not too prolonged but he bore it with remarkable fortitude and at no time would he allow it to interfere

with either his work or his enjoyment of leisure pursuits.

During the war in the Red Sea he first became acquainted with underwater activities and he developed this interest in Australia. It came to full fruition in Canada where he became Chairman of Instructor Certification for Ontario Underwater Council and Chairman of Safety and Accident Research for the Ontario Underwater Council and the Association of Canadian Underwater Councils.

In 1976 he almost moved again. He had applied for the post of Flight Surgeon with N.A.S.A. in Houston, Texas and was selected from 600 applicants. For family reasons he eventually decided to stay in Canada.

Wherever they were he and his wife Lesly, who has been of immense help to him throughout his career, kept a home and were always most charming hosts. To Lesly and their four children the thoughts of all his friends must go at this time.

W. G. T.

Clubs' Union News

In last month's news I managed to apportion blame for large sections of the Union's activities without actually saying what I was up to. So the time has come to reveal the campaign that has been preoccupying me for the last few months.

One major problem is longstanding and widespread dissatisfaction with the catering facilities used by the student and medical school staff at Guy's. In order to bring this to the attention of the authorities Dr. Weinman and I drafted a letter to the Dean asking him as Chairman of the catering committee to convene a meeting of the committee in order to discuss some proposals for extensive reorganisation of the catering service at Guy's, by amalgamating the School and Hospital systems. Prior to this meeting I discussed this possibility with hospital caterers and many interested members of staff. All this was in addition to canvassing opinion from as many students as I could.

Almost without exception the attitude of those who regularly use the Upper and Lower Spit is one of apathetic despair with the service offered. I illustrated the chronic nature of the problem at a special meeting of the catering committee using quotes from both the *Gazette*'s correspondence columns and the almost universal condemnation of the service that has been meted out via *Passim* over many, many years.

In the Medical Undergraduates' presentation to the University Grants Committee at their recent visit we highlighted the inadequate facilities offered by the present catering system. Philip Razzell, who was responsible for delivering this address, stressed the chronic nature of the problem and asked the UGC to consider favourably *"any scheme suggested by our school for the improvement of these catering facilities"*. Professor Trethowan of the UGC immediately responded, "My God *the Spit was awful in my day, have they done nothing at all?"*

Upper Spit food achieved near international renown when Egon Ronay's Guide commented that Doctors were served with lamb and

tomato pie *"which looked like corned beef hash and had no flavour of lamb or tomato"* and *"The boiled ham was too salty and fatty and the amount was miniscule. Cabbage was boiled to desperation and mashed potatoes were not completely mashed."*

In the Clubs' Union also there have been numerous motions passed at general meetings deploring the service—even emergency general meetings called on this very issue! Every President that I can remember being elected for the last five years has included in his manifesto or initial address the solemn promise that a thorough reform of the Spit, or integration with the Hospital service, was to be pursued energetically. All such attempts have been complete failures, and this has resulted in the prevalent mood of frustration, both with the service and the lack of interest shown by the Medical School.

Students, as is well known, take advantage of the hospital canteens —quite understandably.

The Medical School staff have every reason to bewail the recent deterioration in facilities available at the school. The dissatisfaction is again blunted because many staff, including technical and clerical, use the Nurses' Home, when they have no more entitlement to do so than the students.

Another point is the difficulty that academic and clinical staff experience when they want to meet for lunch. The medical school canteen hardly encourages those who have no choice but to use it, let alone ever enticing those staff with clinical appointments over to the inner recesses of the school and so foster inter-departmental contacts.

After berating all those present at the meeting with this miserable catalogue of complaints I presented a draft plan which we thought could offer a better service and be cheaper for the school and hospital to run. The suggested scheme of catering is as follows:

For breakfast the Nurses' Home could be open between 7.30 and 10.00, the lower Spit open between 10.00 and 17.00 with a sandwich bar style service; that is to say with savories, pies, rolls, sandwiches, pastries, fruit, beverages and light snacks on offer. The Upper Spit open between 12.30 and 14.00 with the same range as the Lower Spit, both of them also selling salads during this lunch period. The Nurses' Home and Tower restaurants open between 12.00 and 14.00 serving food as now. In the early evening the Nurses' Home could be open between 18.00 and 20.00 and by using the largest half of that restaurant it could easily cope with all the staff and students who would want to use it. In the late evening and early hours one restaurant would still need to be open for those working night shifts. All the eating places would of course be open to *all* Guy's staff and students. The scheme I have outlined would achieve savings by the closure of the medical school canteen, the Lower Spit for breakfast, the Upper Spit for evening meals, and possibly the Sandwich Bar. But I must emphasise that it is only a draft plan and it will need looking at by professionals to see if it is workable both in terms of capacity and convenience to the customers.

This list of complaints and ambitious ideas for improvements were not particularly original. However, after seeing many people on the hospital side and harvesting data collected by previous Clubs' Union officials, as well as enlisting the help of some well motivated fellow

students—who carried out checks on the numbers of non-NHS staff using the hospital facilities—we were in a position to dispel some of the fallacies that have surrounded the issue of amalgamation.

For instance it has been suggested that there is a policy of direct subsidy from the DHSS. Apparently this is not so, but there is a complicated system of charges as part of the legacy when much of nurses' wages were deducted at source; for accommodation, uniform cleaning and so on. There was then a need for a cheap meal for such people. Here the charge is 25% on cost of food (this means in the way that things are accounted for in the catering trade that if food cost 75p it would be sold for 100p). The rest of the meals (though all meals are available for anyone to buy) have at the moment a charge on cost of 40% (if bought for 60p sell for 100p) and this rate applies for the bulk of the food sold.

Other hospitals interpret the two tier system in a different fashion and some Area Health Authorities have in effect abolished it completely. The important message I think, is that the hospital system is much more flexible than it is made out to be. Another complication with respect to the price of food is that students are not charged VAT. At University College Hospital where they have quite recently amalgamated the hospital and the medical school canteens it was found that the greater purchasing power of the larger concern meant that there was very little change in the price of food served to students even though they now pay VAT with the hospital staff.

At Charing Cross also the refectories for all the staff are run by the same combine and at Manchester, Glasgow, Belfast, Bristol, Bart's, Royal Free, Nottingham, Southampton, New Cross, Lewisham and all the other hospitals where we do regional appointments clinical medical students share the hospital facilities; so there are obviously no "in principle" objections to eating in hospital canteens.

The University Grant Committee has published "notes on catering" which included the following sentiments: ". . . *Although actual management need not necessarily be amalgamated, all catering requirements and facilities, . . . should be assessed together. Furthermore, co-operation between different units is usually very desirable . . . With the general trend towards snacks, and for staff and students to fend for themselves many universities find themselves with too many catering outlets or outlets of the wrong sort, e.g. refectories where the need is for snack bars. . . . More often than not (competition) merely means . . . losses all round. Here the only course must be a detailed examination and cutting out of redundant outlets, even if it means some catering accommodation being directed to other uses (and the equipment sold).*"

Following the district catering manager's comments in the local and student press after the Egon Ronay scandal, I approached him to see if he was truly enthusiastic about improving the catering service at Guy's for all who work here.

Having found that he was, I then asked him to write a letter to the Dean and I indicating the hospital services' interest in opening discussions. He passed this request on to Mr. Thomson who is the assistant district administrator and in charge of the Hotel and Support Services. In his reply he says; *'We will of course welcome the opportunity to*

discuss the rationalisation of the catering facilities on the Guy's site as we can see advantages to both the Medical School and the Hospital from such a rationalisation. I am sure others can see disadvantages, but this obviously produces a need for discussion rather than ignoring some of the problems that have been created at present.

"I am obviously unable to enter into any firm commitment without discussion of the advantages and disadvantages. I would repeat, we would be willing to have those discussions."

This then was the case for re-examination of the Guy's catering system as I presented it to the Medical School Catering Committee on April 4th.

In response to this the Dean suggested that we set up a working party consisting of himself, Dr. Weinman and I, with Mr. Bompas as secretary, with the mandate to open negotiations with Mr. Carruthers (the District Administrator), Mr. Thomson and Mr. Soden to see if a scheme such as I outlined were feasible.

I appreciate that there are enormous financial and administrative difficulties involved in such a plan and that it will be peculiarly difficult to balance the interests of the various groups but, as I have already emphasised, the ineffectual attempts to improve the student service witnessed in recent times leads me to believe that things have come to such a pass that some extensive reorganisation is the most promising avenue to explore in the hope of achieving any real improvement.

Chas Newstead

Notice

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Appreciation

Pam Jeffries

This month the *Gazette* bids farewell to Pam Jeffries who has been Nursing Correspondent for almost ten years. Pam is leaving because she wishes to encourage others to contribute their comments and opinions to the *Gazette*. Without resorting to trite eulogy Pam has always written as she has thought and as a consequence has invited controversy. We will be sorry to lose her from the staff and wish her the very best for the future. At the same time we welcome Sister Julia Fabricius to the *Gazette* and look forward to a long and happy association.

Guy's Cross Channel Sponsored Sail

On 25th May four dinghies will attempt to sail from Dover to Boulogne to raise money for the RNLI and for the Sailing Club. They will be accompanied by two larger yachts equipped with VHF radio.

The money raised for the Sailing Club will be used to buy two dinghies to be based at Burnham-on-Crouch where we have a floating clubhouse. If you are prepared to sponsor them please would you fill out the coupon below and send it to: Secretary of the Sailing Club, Boland House, Guy's Hospital, London Bridge, SE1 9RT.

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Vicious Circles and Disease

by T. K. DAY, Registrar Department of Surgery

Medical writing contains many references to the operation of vicious circles in disease processes.[1] This mechanism is usually forwarded as an explanation for the perpetuation of a disease, some "underlying cause" being the basic aetiology.

However, the very ubiquity of the vicious circle mechanism suggests that its role is central to the causation of disease, and the concept of a self-perpetuating state of abnormal function is essential to the distinction of illness from health.

Homeostasis and health

Claude Bernard's "constancy of the internal environment" is a principal characteristic of living matter. The ability to maintain such constancy within a cell membrane must surely have been a prerequisite to the development of the mechanisms responsible for cell reproduction and metabolism. In the absence or breakdown of the homeostatic machinery, death is inevitable.

It is possible to view the state of disease as occupying a relatively precarious position between influence displacing, and the total dissolution consequent upon an adverse influence displacing the normal homeostatic mechanism beyond its capacity for correction. However, even in the most acute sort of illness, for example acute otitis media, this middle ground can be seen not to exist. Either the responsible organism should be promptly removed by a brisk inflammatory response and the state of health remains undisturbed, or there should be an overriding infection resulting in the patient's death. The very existence of acute otitis media as a disease entity points to some alteration in normal homeostasis.

Thus, far from representing an unstable equilibrium between adverse stimuli and the corrective influence of homeostasis, disease occupies a position of stable equilibrium in which normal function is altered but not destroyed.

Control mechanism and disease

If adverse external stimuli are unlikely to maintain a sustained state of abnormal function in the face of corrective homeostatic mechanisms, it is in dysfunction of homeostasis itself that the basis of disease must be sought.

The control mechanisms responsible for the maintenance of normal physiology have been shown in many instances to be analagous to the servo mechanisms devised by engineers to control the function of electronic circuits and machinery.[2] The essence of such controls is the presence of a negative feedback link, whereby a change in the output of some process automatically controls the input in such a way as to maintain a stable state. For example, in the process of digestion, the secretion of gastric acid originally stimulated by the ingestion of food is inhibited when the products of digestion enter the duodenum, by means of a negative feedback link mediated by enteroglucagon, thus maintaining the

gastric pH within set limits. To provoke a state of sustained dysfunction, that is, disease, it is necessary to interfere in some way with the control mechanism.

Vicious circles and negative feedback

One way in which control circuits may be disturbed is by interference with the negative feedback loop. The way in which this occurs in disease and thereby establishes a vicious circle may be seen in the following examples:

Itchy eyes: after tears have washed away a foreign body, irritation often persists. A vicious circle of irritation—rubbing—irritation has been set up, which may be broken by dissuading the patient from rubbing his eyes or applying local anaesthetic drops and an eyepad. The normal control mechanism whereby pain inhibits interference and rests the part[3] has been altered by a *reversal of polarity* in the feedback loop. What was negative feedback is now positive feedback or a vicious circle.

Respiratory failure: a rise in the arterial pCO_2 normally stimulates ventilation. Beyond a certain level however retained CO_2 depresses the respiratory centre, a *reversal of polarity* in the feedback loop which sustains a vicious circle.

Itch—scratch: the scratch response to minor irritation may be seen as a homeostatic reaction aimed at removing the source of the annoyance. When infection of the skin is induced by the scratching this in turn may produce further irritation, which by introducing an *additional link* effectively reverses the polarity of the feedback and sets up a vicious circle.

Rheumatoid disease: antigenic material is normally rapidly cleared from the blood by the action of antibody and macrophages. The polarity of the negative feedback exercised by the action of antibody in removing antigen is reversed if the antibody itself becomes antigenic (rheumatoid factor) and a vicious circle is set up.

Anxiety and palpitations, diarrhoea, etc.: the fear reaction normally acts to remove the organism from the fear-provoking stimulus. When fear induces somatic symptoms and these in turn induce fear an *additional link* is introduced into the mechanism effectively reversing the polarity of the feedback loop. Treatment directed at relieving the somatic symptoms appears to be as effective as anxiolytics, tending to confirm the idea that a vicious circle is responsible.

Pain and spasm: the tendency of muscles to contract around an injured area usually protects it from further injury. In the case of anal fissure however, the muscle spasm provokes further injury as the normal reflex tendency of the anus to relax during defaecation is overwhelmed by a more potent and primitive homeostatic response. The feedback is inappropriate: spasm produces more injury rather than less and by a reversal of polarity of the normal anal reflex a vicious circle is established. The circle may be broken and the disease successfully treated, by interrupting it at the point of pain (by local anaesthesia) or at the point of spasm (by internal sphincterotomy).

Clinical applications

The treatment of disease is traditionally taught to be that of the "underlying cause" plus whatever symptomatic measures may be necessary. This concept becomes largely invalid when the disease is produced by a vicious circle. Some treatments which are accepted empirically but which appear to have no justification in terms of their effects on the presumed underlying pathology gain some theoretical validity when viewed in terms of their role in breaking a vicious circle. The use of beta-blockers in the treatment of anxiety-induced palpitations is an example.

Once freed from the strictly cause-and-effect view of disease aetiology one can search for the vicious circle operative in any disease that presents therapeutic problems. The process is unusually informative, suggests new lines of research and sometimes of treatment. When a vicious circle is identified therapy aimed at breaking several links is often more effective than that aimed at breaking one link alone. For example, a vicious circle appears to exist in rectal mucosal prolapse. The patient is constipated, strains at stool, produces a mucosal prolapse which induces a sensation of faeces in the rectum, and this in turn stimulates further straining.

The constipation may be relieved with bran, the partial mucosal prolapse banded or injected, and the inappropriate straining prevented by the provision of a daily glycerin suppository. This combined approach rarely seems to fail.

The identification of vicious circles may furthermore draw attention to aspects of disease pathology usually forgotten and untreated. Two such circles were identified in a middle-aged lady with a recurrent benign gastric ulcer: (i) loss of appetite leading to a tea and toast diet, a state of malnutrition which contributed to exacerbating the ulcer and consequently the anorexia; (ii) illness leading to time off work, and financial embarrassment resulting in poor nutrition and worsening of the feeling of ill health. Dietary advice and a supplementary financial allowance were added to carbenoxolene therapy. She returned to work, the ulcer healed and she has remained well since.

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Shakespeare at Guy's

by BEN NEVIS

Shakespeare possessed at least two medical books, Bullein's *Bulwarke of Defence against all Sicknes, Sorres and Woundes that do Daily Assaulte Mankinde* and *Death* by John Hinton. Records show that his bedside manner owed a debt to Galen, his diagnostic

technique to Paracelsus and his success to pure fluke. Here I offer a specimen (sic) from one of his ward rounds:

Enter the Stratford Bard, resident surgeon Mr. Trellis, Syringe and Platelet (two fools) Attendants.

Shakespeare (*for it is he*): What ho! Sirrah, how fair the sun breaks on this fine morn. Who today comes before the gaze of medical science. Ah! Fair Lady, thrice scarred by the surgeon's hand, mark you sirs!

Trellis: You smell this business with a sense as keen as a dead man's nose, for verily these are stretch marks. She has, of late, spread herself into a goodly bulk and has had her pond fished. Physic for it there is none, for 'tis a bawdy planet.

Patient: Tell me, what think you of my sickness now? I am made worse by spells and medicines bought of mountebanks.

Shake: Such poisonous compounds are the movers of a languishing death but be not afeared for I shall supervise your diagnosis. Ah! A pleurisy, I see it!

Syringe: Mark you, tis a most pestilent contagious fever; she must bleed!

Trellis: Sirrah, by no means.

Shake: I say bleed.

Trellis: I say 'tis dangerous!

Shake: And I say . . .

Trellis: Either thou art most ignorant by age or thou wert born a fool, and anyway, I am the consultant here.

Shake: 'Tis hoped your sickness is discharged but, strike me, how thy temperature sunward soars. A strange apoplexy colours thy brows. Have you recently been abroad or even to the seedier parts of Soho, pray?

Platelet: Most vile insinuation, for this is no lewd minx.

Shake: *Nobody asked for your comments fool. I fear that thou art plagued* by the pox, the Neapolitan malady. I viewed your urine and the hypostasis, thick and obscure doth make thy danger great. Your veins are full of accidental heat, whereby the moisture of your blood is dried. Your artiers, which alongst the veins convey the lively spirits which the heart engenders, are parched and void of spirit. Which, being the cause of life, imports your death!

Trellis: What counselling is this, what evidence? What facts; sirrah. What authority possess you for this strange diagnosis. This is Guy's Hospital not RADA. Speak!

Syringe: Aye, to be sure nature has framed strange fellows in her time but methinks this the biggest oddball yet.

Shake: Sirrah, I have a friend, a quack-salver named Lear . . .

Platelet: Everyone knows that King Lear was a peeping Tom, a rogue . . .

Trellis: Enough! I have heard enough infantile bickering. As for your quack, all his ingredients are a sheep's gall, a roasted bitch's marrow, some few earwigs, pounded caterpillars, a little capon's grease, and spittle, obtainable on prescription only.

Syringe: Ah! The blest infusions that dwell in vegetives, in metals, stones . . .

Trellis: Away! Now, Lady, I must tell thee that thy principal dolour lies in the region of the liver and there is inflammation and tumefaction. I will use a *quadrangular plumation,* and engage *sanguis draconis* with powders incarnative which shall I temper with oil of hypericon and other liquors.

Shake: And I shall cut off all perished members and boil . . .

Trellis: Zounds, you shall be sent down very shortly with malady of sign up.

Patient: I have no sickness but this Thespian's presence.

Trellis: Aye! *For Physic and Forces*
His equal there scarce is
His Forces are Physic
His Physic a Force is.

Syringe: Of him it is said: Before you take his cure or pill, take leave of friends and make a will.

Shake: I'll see my solicitor about this, 'tis defamation sirrah.

Trellis: Thou monster ignorance! He finds not the sign and so misses the accent of disease. I will allow thee one last chance at diagnosis. Proceed.

Shake: You exude, fair lady, a leperous distillate . . .

All: Good God, he's off again.

Shake: . . . or, in terms more accessible, you are buggered. Hold fast and take thou this phial of arsenical compound. Presently, through all thy veins shall run a cold and drowsy humour which shall seize each vital part, and no pulse shall keep her natural progress.

Platelet (frantically): Murder! Murder!

[*exit Platelet to the Police Station*]

Shake: Here within this place is cured
All the griefs that were ever endured
Palsy, gout, hydropic humour
Breath that stinks beyond perfumer!

[*Enter the Police*]

Shake [*being carried off*]: Sirrah, unhand me, unhand me I say! Madam I have a new play opening at *The Globe,* Borough High St., fancy the part of ghost!

(Shakespeare never qualified but did leave a total of 712 medical references in his plays, and mentioned some eight doctors of whom the first was Dr. Caius in The Merry Wives, who was reputed to be based on Dr. John Caius, founder of Caius College, Cambridge.)

"Issues in General Practice" Contributions should be sent to The Editor, Guy's Gazette, 16 St. Thomas Street, SE1 9RT.

Information Services for the General Practitioner

by **Professor P. M. HIGGINS**
Department of General Practice

Doctors are reared on a rich diet of facts. The process begins in their student days and continues unabated until they retire. To such an extent that it is difficult for doctors to think about education without associating it with the acquisition of information. Yet, particularly after training is completed, education ought to be much more concerned with general professional development, with the development of skills and with intellectual stimulation and refreshment, but so overwhelming is the need to process the continuous flow of information to claim the major share of attention. It would be helpful to the general business of education and development in this wider sense if we could separate from it the need for information.

The GP has a special problem in keeping up with the facts since he has such a range of medicine to cover. There is no condition known to any branch of medicine that may not at some time or another present to him and it seems to follow that no item of information can be dismissed as entirely valueless; somewhere, sometime, some GP (and some patient) might be glad that he had it in his head ready to be put to use.

There is, indeed, a pervading feeling that the GP does not have anything like enough information ready in his head and exponents of every individual branch of medicine are eager to suggest more bits of knowledge that he ought to have. He is therefore bombarded with information. It comes in all sorts of forms and covers all kinds of subjects: lectures, filmshows, demonstrations, advertisements, handbooks, circulars, reports, letters (both official and non-official), all in the business of selling him the "facts". Through his letterbox pours an unending stream of information of all grades of quality and relevance; not even official communications appear in the standard form or in any co-ordinated way.

In medicine one learns fairly soon that the "facts" have a relatively short life; it might indeed be considered more useful to know how to identify and to ditch the lumber of the past than to know how to acquire the latest information early in its pre-obsolescent phase. It is not surprising therefore that the GP faced on the one hand with the immensity of the task and on the other with the gross inadequacy of the tools, decides not to undertake the job at all. After all, the doctor's memory banks may not be inexhaustible—the container is certainly unexpandable—and it might be sensible to leave a margin for the business of living.

The sorts of information that are most difficult to deal with are that which is changeable and those which are highly complex.

Examples of the first are immunisation programmes or the management of early myocardial infarction, and of the second drug interactions or laboratory results; the figure (fig. 1) sets out one view of what information should ideally be given about a standard laboratory investigation if the clinician is to have a soundly-based view of what the results mean.

Fig. 1.

Test: Serum uric acid

Population: To be characterized by age, sex, race, geography, socioeconomics, etc.

Usual Range: 3 to 6 mg/dl

Referent Value	Diagnosis	Predictive Value, %
7.0	Gout	21
8.0	Gout	35
9.0	Gout	82

Taken from *Beyond Normality: The Predictive Value and Efficiency of Medical Diagnoses.* R. S. Galen and S. R. Gambino, New York, 1975.

For information that changes only slowly the best instrument is still the written text, for all the rest the ideal solution is to store the information not in the doctor's own memory bank but in a memory bank that is instantly accessible to him. We already have one model of how this can be done with present techniques: the Poisons Information Service at Guy's that makes available to the GP with a particular problem a vast store of knowledge at the time he needs it. Another service in the process of development here is a Drug Information Bureau.

Advances in information technology and in computer technology will soon offer opportunities to develop such services and to expand their cover to other subjects such as problems of clinical management or of diagnoses or of investigation. With the existing technology such as that developed by the GPO's "Prestel" system it would be possible to offer to the GP up-to-date lists of facilities available both locally and nationally; hospital waiting lists, for example, or addresses and telephone numbers of voluntary associations or social and welfare services. A terminal in the health centre or group practice linked with a central computer data bank would enable the GP to have, at the moment when he wants it, the latest view about immunisation programmes or about the treatment of emergencies. Laboratory investigations appropriate to the problem could be suggested and some assessment of the significance of the results given.

Such services could eventually enhance the capability of the general practitioner to cope with problems while freeing him from the need to spend the precious hours available for educational purposes on the acquiring of items of information that he knows will change or that he

does not know when he will use. Further developments in the future could enlarge still more his capacity.

Among these are the use of visual display units to allow interaction with doctors and others at a distance. Some American workers have demonstrated that complex television transmission facilities which enable remote viewing of documents, X-rays, ECGs and even patient examination procedures, can help nurse practitioners in outlying clinics to cope with problems that would otherwise have to be referred to a doctor (Dillon *et al* 1978). There is a long way to go before that sort of system is commonplace in general practice in this country but the techniques are available now to begin the development of services that could put at the elbow of the practising doctor a wide range of information at the time when he needs it.

The questions are—can we define the GP's need for information more precisely and can we redeploy educational expenditure to meet these needs in a new way?

The Family and the Handicapped Child

by Daphne Economou

A while ago, when I first started thinking about the subject of this paper, I was worried by its very personal nature. Later I realised that an apparently subjective problem may sometimes be transformed into a question of wider human concern, if its close connection with the world is discovered and understood. When this association occurs, it brings release from the loneliness of what is purely personal and lends a certain dignity to what is recognised as being a general question of society. It is in this spirit that I would like to consider the problem of the handicapped child and its family.

A year before my own spastic child was born, I dreamt that I was holding in my arms, quite a big child, four or five years old, which seemed, apart from its size, to be physically still a baby, unable to support its weight or stand upright. The importance of this dream was not that it was undoubtedly predictive, but that its message was completely lost on me. I did not recognise its implications at all and I only remembered the dream years later, when it had already come true. So the warning that might have existed was wasted. Yet, the symptoms of abnormality in one's own child are soon evident. Both parents know immediately that something is wrong, but imprisoned in their own ignorance, each keeps his apprehensions private, while guarding the other's secret and in a primitive superstitious way, prays that the unknown fear will go away if it is never put into words.

This is the time, when one is reminded of the beautiful words of Leon Bloy *"Man has places in his heart that do not yet exist and into them enter suffering and love in order that they may have existence"*.

The watching, waiting parents discover new places in their hearts through suffering and love and finally entrust their suspicions to one another.

It is at this point that the experience of having a handicapped child begins in its entirety. This is the experience which must be gone through and for which reason is no substitute. We cannot refuse our support to a venture that challenges our whole being and requires our total commitment. Experiences cannot be made—they happen—but we can however draw closer to them. That much lies within our human reach. We cannot and must not refuse our participation for only if we dare to face what is real, can we survive it.

So the search begins. The parents, together now, set out to discover what ails their child. They ask for information and for immediate solutions. They believe that only this can help them at this stage to face their fear, their feeling of personal guilt, of isolation, of segregation, of unfairness, their terrifying vista of a dark future. They discover that in science there are no absolute truths, that the laws of official science are inadequate to solve all the mysteries of nature. They ask for help and they are usually offered one of several evils. Either confused, unintelligible opinions, stock phrases, evasive answers or scientific data elevated to the rank of dogma or, worst of all, conflicting views. All this is the product of doubt. In their quest, parents will invariably meet those special people, brave enough to be immoderate and one-sided and to whom we owe our greatest discoveries, but sometimes not wise enough to guard against the fanatic defense of their onesidedness. So the parents find themselves emmeshed in contradictions that seem to take the form of a conspiracy of words.

Simple things seem always to be the most difficult to express, which is perhaps why so few parents are ever told that little is still known about cerebral palsy.

Yet, even if the ideal conditions of diagnosis, treatment and parent guidance, that already exist, were to be made available to all parents, undoubtedly the feeling of chaos and disaster would be alleviated to a degree, but the initial shock would still be there.

What usually happens in the story is this: The parents still in a state of shock begin to suffer the imposition of well-wishers, who would advise and help them, so they find themselves in the paradoxical situation of being over-advised by the unqualified and inadequately advised by the qualified. So unable to find help outside themselves, they turn towards their child and discover him as a human being instead of as a medical case. And here comes the first happy break for everyone. They discover, first of all that an exceptional human being is a gift of nature and as such a handicapped child is a gift of inestimable value. In their love and knowledge of their own child they discover that man is not a machine, in the sense that he can consistently maintain the same output of progress. He can only meet the demands of outer necessity if he is well adapted to his own inner world and to the conditions of his environment. So the parents automatically begin to create a good environment in which their "special" child will be happy and consequently through the child's dependency and need of them they begin to feel happier themselves. They soon realise that all they have to do is to understand and respect the differences in their child and to guard against the futility of wishing to interpret and specify those differences. For the miracle of the handi-

capped child is that, although it lacks so many fundamental specifications, it still functions beautifully as a human being. The ancient Greeks made the wisest and most capable of gods, *Hyphaistos*, a cripple. Of course, the Spartans threw their cripples into the gorge of the *Tavettus* in order to maintain the superiority of their race, until some clever mother hid her crippled child, and lame *Agisilaos* became the greatest King of Sparta. It makes you think.

So let us quickly cease to set ourselves and our child goals and time-limits, casting it in the unfair role of a failure or a success. The competition that normal children face in modern society is often accentuated in the case of the handicapped through over-attention not to their needs as human beings, but to their physical achievements. This is a violence to the self-respect of the child who is entitled to be as he is, not, as Professor Milani said so rightly in Florence, condemned to forced labour in order to compete with his peers. We all have our handicaps, everyone of us, there is no point in dwelling upon them. The important question is our indisputable right to a place in the sun and the pursuit of our own happiness on our own terms. Surely, this applies to the handicapped too.

A family is a loosely woven unit of people of different ages, connected by common blood. A family is not a club, where people of similar age and inclination follow a common pursuit. The members of a family are of course going to react in an unpredictable way to the handicapped child who is one of them. Brothers and sisters and grandparents for a start are going to want to know what is the matter with the new baby. They are surely entitled to know, but here the parents will once more be faced by the ambiguity of scientific truth and the inadequacy of words.

And here the learning stage begins for everyone. The child learns to live quite amicably with its disability, reacting positively to what it can do, and not negatively to what it fails to accomplish. It is usually receptive, eager to please, loving and wonderfully free of stress, a centre of calm for everyone to come close to and derive strength and comfort from. Parents, brothers and sisters and family friends all find that they have something to offer and the handicapped child discovers that what he has to offer is appreciated and sought after. The child acquires his own personal friends and his integration into society begins. Beyond the immediate circle of his family he makes friends that are his alone. His therapists, his teachers and his nurse are very important but so is the house porter who carries him to the school bus, the driver of the bus himself with whom he enjoys a good joke, the local grocer who likes him and always saves him a special banana, the captain on the boat who lets him hold the tiller, the old ladies who call out his name as he goes by, the strangers who lend a hand with his pram, the big boys who take him swimming in the sea and jumping in the waves, the girls who love to dress him and who comb his hair in funny ways, they are all his friends. The well-adjusted cerebral palsy child with his warm hearted nature can make and retain more friends than a normal child could ever have, because so many different people effect his life. This is his wider world. Within the world of his family it is simply a question of love. Love with no conditions, love as a way of living, love as a mutual need.

We cannot always know what is best, we will not always judge correctly, we will frequently feel tired, discouraged and sad, but these natural shortcomings will in no way harm our child. It is, after all, part of the business of growing up to listen to the discords and paradoxes that real life grinds out. The handicapped child must not be bereft of this experience but should share in this natural process.

But what of the future? The child will cease to be a child and will challenge the world from a new view point with an adult's demands and needs. And what if we are no longer there to help? Who will succeed us? We know in our hearts that we must allow growth and change, and must simply trust that somehow nature will not let us down.

Beta-pathy Guy's Charities Week 1979

by Deborah Brooke

The heady atmosphere of Charities Week is now sufficiently distant for its perpetrators to look back with the wisdom of hindsight.

It was hoped that the week would become an annual event, so assessment and constructive criticism are clearly necessary.

Our aims were to raise money and to increase the communication between students of all professions within Guy's. Both of these have been achieved—the final profit was £1,100 and cheques have been sent to all seven Charities. The inter-disciplinary aspect was reflected in the composition of the Committee (Medical, Dental, Nursing, Physiotherapy and D.S.A. students all gave much time and effort) and also in the sizes of the audiences at the events.

One criticism is that we frequently underestimated the demand for alcohol; the Real Ale "Night" finished at 7.30 p.m. when the last drop of 45 gallons was drunk, and the bar held in the Ballroom during dances sold out of beer on at least one occasion.

Despite this, audiences seemed to enjoy themselves and all the events were well attended. This confirmed our impression that advertising was the key to making a profit; the first and major problem was attracting interest. Once founded, however, the interest blossomed into a surge of community spirit. Thomas Guy was even dressed for the occasion!

The Snooker Marathon, played by Michael Craigen and Paul Revell, captured the attention of many (including the University Grants Committee), in addition to raising £100. They played for 134 hours 59 minutes; of the three people who guessed 135 hours, Anne Child won the draw for the bottle of scotch.

For sheer entertainment value, it would be difficult to surpass the Tug-of-War, held in Guy's Park, which attracted a large crowd of onlookers—all of whom gave generously to the collecting boxes. Many of

the teams were in fancy dress, except the Mountaineering Club who took it very seriously, wore their working clothes, and anchored themselves to a nearby tree for safety! Unusual events which actively involve many people are great fun; more of these would be successful next year.

Having created the interest, future inventive programmes should prevent it lapsing, with the desirable result of raising money while augmenting the social life.

Editors' Note:

The charities benefiting from Guy's Charities Week are as follows:
Royal National Lifeboat Institution.
Dr. Barnardo's.
Association for Spina Bifida and Hydrocephalus.
British Homes and Hospitals for Incurables, Streatham.
Charterhouse Ark (Southwark).
Paediatric Research Unit, Guy's Tower.
Spastics Association.

Examinations

by **PROFESSOR KEITH SIMPSON, C.B.E., M.D.**

One of the pleasures of my later academic life was visiting other Universities to examine students at their "Finals". It is an awesome moment for the student, but curiously the wretched examinee always seems surprised to hear his grey-haired or balding examiner remind him that he himself was sitting in that hot seat not so many years before, and is really only too anxious to pass a candidate. Courtesy and a vein of humanity count a great deal: As a student I never forgave a pathologist examiner who sat on the other side at a table twiddling a piece of string, looking in a bored way at the ceiling, saying to each answer I gave *"Go on"*, *"Well all right, go on"*. It was an inexcusable discourtesy and I determined never to subject any young man or woman to it. Finals are never forgotten by any student.

Could anyone fail to chuckle at the unconscious humour of the candidate, so worked up that he writes *"poisin"*, *"succion"*, *"man-slauter"*, *"asprain"*, *"fairwell letters"*, *"maniacle assalt"* and *"perbuty"* —for the adolescent, when he has somehow passed "O" or even "A" level English.

Oscar Wilde himself would have delighted in:

> *"Doctors commit adultery as a part of their professional duty"*, or
> *"When a person has swallowed belladonna he will be* livid"; (a feature of this poison is flushing),

and wouldn't Freud agree that

> *"Women commit infanticide by destroying the cause of their pregnancy"?*

How do you interpret the definitions:

"A subpoena is not enough respiration".

"Partial combustion in brassieres causes CO to accumulate",

or

"Among abortion instruments, various implements from fish-hooks or screwdrivers to a crochet hook or a crowbar, spectackle frames, waxed tapirs *(sic) or among the more talented, slippery elm or the insertion of various household articles".*

Professor Keith Simpson by Henry Bull, Q.C. A sketch made while the author was on a lecture tour in Toronto.

Doesn't this reflect the fertile imagination of the student, striving to absorb the vast amount of factual teaching he gets? Is he not to be encouraged rather than jeered? How can anyone fail to be touched by the student who writes:

> *"This phenomenon is called . . . Oh dear, the word escapes me. I am so sorry . . .",* or
>
> *"Apologies for this shocking presentation, but I am rushed for time."*

A famous pathologist, E. H. Kettle of St. Bartholomews, once told me of the wretched student who, when asked the cause of disseminated sclerosis—a disease that has perplexed generations of doctors—bluffed his way with a muttered:

> *"Disseminated sclerosis, Sir. Er Yes, Sir, Er . . . on the tip of my tongue, Sir. Give me a moment, Sir."*

"Dear me", said Kettle, exasperated but still kindly, *"We don't know, young man. Even God doesn't know.* And now you've forgotten!"

Every medical student remembers his viva voce examinations vividly. *"You examined me, Sir, when I did my 'finals' at Glasgow 10 years ago"*, says a young pathologist whose post-mortem has been criticised by an angry relative. I repeat the post-mortem. It was a competent one. *"I can only report what you have already said"*, I say to him. *"You are absolutely right, and I shall say so"*. And another young man remembers you with affection.

There is an old fashioned but very deep-rooted tradition of regard for the Master in Medicine, and it is a privilege not easily earned nor casually disregarded. Much of the relationship is that of the apprentice for his teacher: he may achieve great distinction himself, but somehow his Master always stands apart—a figure of both respect and affection.

> *"Remember, Sir"*, says a Hong Kong post-graduate of 20 years before, *"Remember, you said you never see opium addict, Sir. Well, we collect some for you to see now. Come across to Mainland Prison, Sir, and we show you."*
>
> *"I read your book, Sir. The case of the landlord chopped up by his lodger: Sir. Ho! Ho! He bought pressure cooker to get rid of remains, Sir. It only told him how to cook vegetables, Sir."*

Nursing

On taking over the job of nursing correspondent to the *Guy's Hospital Gazette*, I thought I should learn more about Guy's Hospital nurses. They after all are the people I represent and about and to whom I should be writing. I had to go to a surprising number of different sources to find any information about them. Although this information is all rather factual, I thought it might be of interest to *Gazette* readers and that it would form a background for future articles.

There are 913 trained nurses employed in the hospitals of the Guy's Health District (that is Guy's, New Cross and St. Olave's Hospitals).

They include 32 nursing administrators, 186 sisters, 386 staff nurses, 203 State Enrolled nurses, 26 midwives, and 80 nursery nurses. There are also 145 nursing auxillaries.

There are almost 900 nurses who are taking trainings of various sorts, either for statutory qualifications or for post registration qualifications which are recognised by the Joint Board of Clinical Nursing Studies (J.B.C.N.S.). The School of Nursing takes 200 nurses a year for the three year training for state registration (S.R.N.). They are divided into four intakes of 50. The written examination is taken at the end of the second year and practical ability is assessed continuously throughout the training. Of these 200 nurses, 12 are graduates who take the same training but qualify after two and a half years. Last year for the first time eight students were accepted for practical experience at Guy's on secondment from the South Bank Polytechnic. These students take a four year course leading to S.R.N. and a B.Sc. in Community Nursing. St. Thomas' and the Westminster Hospital also take nurses on secondment from this course.

The other statutory trainings which can be taken at Guy's are for state enrolment (S.E.N.), for the Register of Sick Children's Nurses (R.S.C.N.), for the Register of Mental Nurses (R.M.N.) and to become a State Certified Midwife (S.C.M.). Sixty nurses a year in two intakes are accepted for the two year training for S.E.N., 30 a year in three intakes for the thirteen month one for R.S.C.N., 27 a year in three intakes for the thirteen months for R.M.N., and 50 to 60 a year in four intakes for the twelve month S.C.M. training. The pupil midwives are divided between Guy's and St. Thomas' Hospitals as there is a combined school of midwifery. Students on the R.S.C.N., R.M.N., and S.C.M. courses are already State Registered Nurses.

The J.B.C.N.S. recognised courses at Guy's are for Theatre Nursing —two intakes of six nurses a year for a one year course, Renal Nursing —two intakes of six a year for a six month course, and Intensive Care Nursing—two intakes of 12 a year for a six month course.

So, there are nearly 2,000 nurses working at Guy's and they are a fairly diverse group. About 1,000 of them are resident in the nurses' homes at the three hospitals and in three other nurses' homes in Earls Court and Bayswater. The majority are female but men are employed and are accepted for all training except midwifery. It is interesting to see that almost half the nurses are students and important to remember that all the student nurses (apart from those on secondment from the Polytechnic) are used as part of the work force of the hosptal. If the Briggs Report is implemented there may well need to be more trained nurses so that the training needs of the students can be better met.

Probably most of these nurses do their work as well as they can, and do not worry very much about the politics of their profession. In the recent Royal College of Nursing referendum about industrial action, less than ten per cent of the membership bothered to vote. The accumulation of uncollected "Nursing Standards" (in which were the postal ballot papers) in the post boxes in the Nurses' Home at that time suggested that Guy's nurses were no exception.

Julia Fabricius

Physiotherapy

Following on from the 1973 McMillan Report's recommendation that "the nursing and remedial professions should discuss present areas of overlap and set out guides to good practice", a joint working party was set up by the British Association of Occupational Therapists, the Chartered Society of Physiotherapy, the Society of Remedial Gymnasts and the Royal College of Nursing. A report was produced last year and is presently circulating in the District to interested parties preparatory to consideration of its local implications.

Regrettably, when the report was discussed regionally at David Salomon's House in Southborough in January, Guy's was not represented by either occupational therapist or physiotherapist, although administration and, presumably, nursing representatives were present. Whatever regional policy was decided is therefore unknown to your neighbourhood remedial professions—a not unique situation. There is, it seems, no direct means either of making our views as a profession known to the RHA or of their consulting us, as there is a Departmental embargo on setting up any more advisory groups, so the best that we can hope for is the development of informal contacts and the opportunity to put forward points of view at regional discussion meetings.

The Guy's OT's and physiotherapists were early participants in an Area remedial professions working group set up pre-Reorganisation, and we have continued in existence with our colleagues from Lewisham, King's and St. Thomas' despite the bland indifference that Area has shown to our offers to act as an informal consultative group when matters affecting our professions are under discussion. We have obtained the agreement of our regional professional groupings to speak on their behalf, and we have been able to influence the content and, indeed, the very existence of courses designed to meet our needs put on by the Regional Training Centre. We also were able to obtain an interview with the Regional Medical Officer and to supply him with some information about the Region's training commitment in, at present, only physiotherapy but possibly later in occupational therapy as well.

One recognises that the pathway to inactivity is one which is so bestrewn with consultation that decision is never reached, but it would seem logical and ultimately time-saving to have the opinions of those whose services are being committed—or altered or even dispensed with —before making drafts, rather than, as an afterthought, asking for comment on a taken decision. It is to be hoped that discussion of "recommendations on the skills required . . . to fulfil (the professions) proper functions in these areas" will be more than a token gesture.

On the whole, the prospects at District level are good—provided that you can ever find out what was ultimately decided in respect of your submission or your advice. But when it comes to what goes on in the Region, there is a very good chance that only a scattered handful will ever find out what is happening, and usually our representative regional boards will only make the discovery because one of the representatives is in that particular handful. As for Area communication, our experience as a working party has not been at all enlightening.

We do not want talking to be a substitute for action, but if the action in question is to be ours and the talking to be yours, co-operation can hardly be said to flourish.

Ronald Cooper

Book Reviews

"Our Bodies Ourselves", by Angela Phillips and Jill Rakusen. Pp. 592. Price £3.50, paperback. Published by Penguin, 1978.

Seven years after the publication in America of "Our Bodies Ourselves"—a health book by and for women, the fully revised British version has arrived. Originally compiled by a collective of women in a Boston health group, it was a major landmark in feminist writing, not only packed with information, but also articulating the experiences and feelings of women about their bodies and their sexuality.

The book ranges widely through many topics including birth control, abortion, pregnancy, parenthood, sexual relationships, nutrition and the N.H.S. It successfully demystifies many areas of medicine, providing women with information normally only found in a less comprehensible form between the covers of medical textbooks, and there will undoubtedly be some in the medical profession who will regard this book as a threat to the (largely male) monopoly over information on gynaecology and obstetrics. The book also questions many areas of medical intervention like induction of labour, treatment of the menopause, and breast cancer, and the British authors have worked hard to update the information on controversial areas. The discussion of such topics is well considered, neither one-sided nor black and white, an approach the average medical student may well find disturbing! In the chapters on relationships, the personalised accounts will provide reassurance and strike home for many women readers; for men, they will deepen understanding of women's sexuality far more than all the surreptitious glances at the coy agony columns of women's magazines.

Inevitably, the breadth of material covered occasionally results in a frustrating lack of detail, though bibliographies refer the interested reader on. More useful, especially to heatlh care professionals, will be the comprehensive lists of help, advice and campaigning organisations on various aspects of women's health in Britain.

EVE BARTON,
Dept. Pharmacology.

"Ward Management and Teaching", 2nd edition, by Ellen L. Perry. Pp. 336. Price £6.50. Published by Baillère Tindall, 1978.

In the preface, Ellen Perry says that this book is primarily directed to nurses preparing for their first appointment in charge of a ward but will be equally useful to more experienced staff. She has certainly succeeded in her aim to be of assistance to nurses in charge of wards in all types of hospital. It is a book that every ward sister should read.

It is divided into four sections: "The therapeutic team", "The use of resources", "Working for the future" (which is about learning and teaching on the ward) and "The hospital and the community". The ward sister's work is complex and includes many different activities. Many sisters would find it hard to describe all that they do. Ellen Perry manages to separate the different aspects of the job without losing sight of the whole, and discusses each in a lucid and instructive manner. Her attention to detail reminds one that this is an imporant characteristic of the good ward sister. She also describes some of the committees, legislation and management structures which directly or indirectly affect the ward sister's work, and discusses briefly the work of many of the sister's colleagues. She expresses opinions on a wide variety of subjects, such as ward design, the use of disposable equipment and the training of nurses. She is perhaps a little dogmatic about some things, for instance the use of showers rather than baths. One would have to agree that showers are hygienic and labour saving, but surely whether they are pleasant is a matter of opinion.

Ellen Perry expects high standards from ward sisters and her book will help them achieve these. She obviously also expects that administrators, works departments, supply departments and other people on whom the sister depends will work to a high standard and her book does not tell the sister how to cope with the increasing frustration when this is not so.

JULIA FABRICIUS.
Sister.

"Gynecologic and Obstetric Urology", by Buchsbaum and Schmidt. Pp. 461. Price £24.00. Published by Saunders, 1978.

In the continuing trend of multi-author texts, this book can boast no less than thirty-one contributors, an index of its comprehensiveness. As the title indicates the book covers the urinary tract in both gynaecology and obstetrics. Scanning through the various chapters, one is impressed by the obvious depth of experience on which the authors are able to draw, adding credibility to the overall content. As to be expected there is a strong surgical bias throughout the book, most of which is accepted practise. Detail relating to anatomy and physiology is always more difficult to relate factually, and in this respect there are undoubtedly some points of issue. For example, not all would now agree that the muscle fibres around the trigone are one and the same as those in the urethra since the work of Donker & Dröss, and Gosling, both carried out in early embryos. Similarly the chapter by Lepides relates mainly to his work undertaken in the sixties, some of which has now been modified. On balance this book is a valuable contribution to any gynaecological library as a reference manual, which at £24 is bound to restrict its circulation to the individual buyer.

T. M. COLTART,
Director, Dept. Obstetrics.

"Medical Neuroscience", J. R. Daube and B. A. Sandok. Pp. 454. Price, £13 cloth, £9.75 paper. Published by Little-Brown, 1978.

This book provides a synopsis of basic neuro-anatomy, neurophysiology and neuropathology. Unfortunately neuro-pharmacology is not included. The structure of this book is unconventional in that the nervous system is looked at from three diffeerent angles. The first third is a survey of the neurosciences, mainly outlining general principles. This is followed by an account of longitudinal systems, e.g. the motor system or the cerebrospinal fluid system. Finally recognition of the neurologists need to localise disease processes is considered. Here the nervous system is described at various horizontal levels, e.g. the peripheral level or the spinal level. Overall the approach adopted is an improvement on that found in conventional textbooks, with the disadvantage that looking up specific topics is difficult, because of fragmentation of the information.

The book covers its field comprehensively and the bulk of the numerous illustrations, which are pencil drawings, are simple and immediately understandable. The text is easy to read, and this is partly due to the fact that the authors do not enlarge on controversial points, instead they give only their, usual well founded, opinion. Unfortunately there is one disagreeable feature to this book, namely the complete absence of references to the literature or suggestions for further reading. Apart from this "Medical Neurosciences" can be recommended as a clear, simple introduction to this field of knowledge.

W. HAMANN,
Senior Lecturer, Dept. of Physiology.

"Cash's Textbook of Chest, Heart and Vascular Disorders for Physiotherapists", by Ed. P. A. Downie, Pp. 383. Price £4.50. Published by Faber.

The second edition of this book, which was first published with Miss Cash as editor in 1975, is edited by Miss P. A. Downie and has been completely revised. The first edition, which had five contributors, was essentially a compilation of five small books and there was inevitably some repetition. Now, six more contributors have been added to Miss Cash's list and the pack has been shuffled in such a comprehensive way that it is difficult to make a straight comparison between the two editions.

We still have the two incarnations of the triple goddess of respiratory physiotherapy in Misses Innocenti and Gaskell, whose contributions, while up-dated, are essentially unchanged, and who warily give credit to one another's alternative points of view. The section on Intensive Care, which was good in the first edition, has been usefully expanded and re-written, and the introductory chapters on basic anatomy and physiotherapy, while similar to those of the earlier book, are now much better arranged and more concisely presented so avoiding recapitulation and repetition.

The new contributors all add important material and the chapters on Cardiac Arrest, Auscultation and on Lung Function Studies I found particularly interesting. The editor makes the point that she needs suggestions and criticism from her readers if she is to provide what they require, and the appearance of this, her first revision, gives cause for belief that future editions will continue the selective slimming-down and building-up that so many of us seek in other contexts.

A good book, this, not just a money-catching re-hash of the first edition, but one which ought to take its place on the bookshelves of all physiotherapy departments.

R. J. COOPER,
Principal, School of Physiotherapy.

"Radiographic Positioning and Related Anatomy", by I. Meschan. Pp. 590. Price £14.50. Published by Saunders, 1978.

This large volume is the second edition of a book originally published ten years ago. As it states in the preface, it has been designed for the average radiographer who desires a reasonably concise manual on practical positioning and related anatomy, and includes modern specialities such as computerised axial tomography, brain scanning, and vascular investigations.

This book is divided into sixteen sections, and starts with an outline on routine procedures, suggesting what projections to use for various examinations. This is a good idea for those departments where a list of procedures is not already laid down, but I did feel some of them were unnecessary, especially the suggested routine for determining the bone age on a small child. This is followed by a short chapter on equipment, which is concise and to the point, but could perhaps have been omitted in favour of other text books on this subject. The few pages on safety recommendations are welcome, as this book may find its way to many countries.

The following sections include all relevant X-ray investigations for each part of the body. Take, for example, the skull, which starts with routine projections, then continues to the ear with tomography, facial bones, teeth and pantomography, sialography, cisternomyelography, and ending with axial tomography.

The layout of the book is excellent, as each reproduced X-ray is accompanied by an illustration of the position together with a clearly labelled anatomical drawing, and a labelled diagram to correspond with the X-ray. The text describes the positioning with added points of interest. In some cases, there is also additional labelling of the X-ray film.

On the whole, the anatomy is fairly detailed, with, in some cases, extra information pertaining to pathology. This adds a great deal of interest for the student who can more readily understand why certain investigations are necessary.

Criticisms are few, there are obvious omissions such as no mention of tomography of the hilar region in the chest, or on the uses of ultrasound in preference to radiography. All of the illustrations of positioning of the upper extremity show the X-ray tubing aiming at the gonads, clearly undesirable. I also thought it a pity that no exposures are given even if only to act as a guide. The labelling of the scans in the section on computerised wholebody tomography are rather too detailed as the reproductions are not all that clear. However, this is certainly a book which should be of great value in an X-ray department or school of radiography, as it has been presented in an interesting manner which should appeal to students of both radiography and radiology.

P. HAMPSON,
Superintendent Radiographer.

"Obstetrics and the Newborn", by N. A. Beischer and E. V. Mackay. Pp. 532. Price £8.50. Published by Saunders, 1978.

The soft cover on this new addition to obstetric literature leads one to think initially that it conceals a short-notes type text, albeit one which is just too large to fit into the pocket of a white coat. On looking inside however we find an extremely comprehensive book and one which is liberally sprinkled with diagrams and photographs, including a whole section of 64 colour plates of excellent quality. The text itself is more or less in note form, but for the most part not short, unless one examines the section on the normal puerperium, the routine care of which fills a mere three and a half pages, or 0.7 per cent of the total text—perhaps rather too short. Unfortunately publication just preceeded the investigation of plasma alpha fetoprotein as a screening test for neural tube defects in pregnancy, so this important aspect of antenatal care is incomplete. Apart from this all aspects of the subject are fully covered including a section at the end entitled "Passing the examination" which ought to appeal to undergraduate readers.

T. M. COLTART,
Director, Dept. Obstetrics.

"Review of Human Physiology", by H. F. Winter and M. L. Shourd. Pp. 563. £8.50. Published by Saunders, 1978.

This book is not what is expected from the title and, in fact, "the primary purpose of this review text is to provide a systematic means of review and self-evaluations of the students' comprehension of major concepts of Arthur C. Guyton's Textbook of Medical Physiology". It is thus a satellite book and "the format is that of a series of cognitive objectives, followed by content review statements for each objective in the form of multiple choice questions and answers".

The multiple choice questions are not the kind widely used in the U.K., and I suspect the somewhat obsessional

approach required by the person who attempts the puzzles in this book, is not a common characteristic of the British medical student, even supposing he could afford to own a copy of the parent book.

I. MACDONALD,
Professor, Dept. Physiology.

"Loss and Grief in Medicine", by P. Speck. Pp. 175. Price £2.95. Published by Ballière Tindall.

This small book attempts to deal with an important and often neglected topic in medicine, namely patients' reactions to loss. It discusses loss at many levels such as physical losses incurred by surgery, sensory losses, losses of mobility, losses of self-esteem and loss of life. With each problem there is a brief account of some of the emotional reactions which can ensue together with some indications as to how psychological support can best be offered. Despite the wide range of problems which are discussed, the author presents a unifying theme which is that all kinds of loss can be followed by a grieving process, which resembles the reactions associated with bereavement. He describes the form of this process and suggests ways of relating to the patient at various stages during it. The author is a hospital chaplain and I was anticipating a book with a "message" but I was pleasantly surprised to find that his views were not at all intrusive. Inevitably there are marks of the author's trade scattered throughout the book and there is a chapter towards the end on the interpretation of death found amongst various religious groups but this can be taken or left according to the reader's inclinations.

This is not a complicated or theoretical book and is all the better for not being so. It offers a straightforward and sensitive account of patients' feelings and needs during many of the difficult times which are encountered in medicine. It is a bit patchy since some problems are quite well described and exemplified whereas others are glossed over, sometimes in a rather simplistic fashion. Perhaps this is to be expected in such a short book. There is a reasonable bibliography which has some notable omissions (e.g. no mention of Brown's recent work on loss and depression) and there is a useful appendix of discussion topics which could easily be incorporated into seminar teaching. This is the sort of book which should be read by everyone who is concerned with understanding patients.

J. WEINMAN,
Senior Lecturer, Unit of Psychology.

"Increased Intracranial Pressure in Children", by W. Bell and W. McCormick. Pp. 485. Price £21.00. Published by Saunders, 1978.

This is the second edition of this book. In view of its length and confined subject one would expect a comprehensive and authorative account of the subject and it is from that standpoint that the book is reviewed.

The book contains some good accounts of particular conditions that cause raised intracranial pressure. The strengths of the book are the pathology and comprehensive references. However, the book has considerable weaknesses which make it rather difficult to know for whom the book is intended. Better accounts of the radiology, neurosurgical aspects and paediatric neurological intensive care exist in other texts.

The format is confusing and not clinically organised in any logical fashion. The chapter on cerebral oedema does not discuss the diagnosis or causes although elsewhere good accounts of Reye's syndrome and lead poisoning are given. Unfortunately the accounts of these conditions are not related to other causes of rapidly deteriorating conscious level. The section on the prevention of head trauma to young children is curiously naive and a good account of non-accidental injury occurs later but is not cross-referenced. Aqueduct stenosis as a cause of hydrocephalus is not related in the text to tumours that can present with hydrocephalus at that site. This sort of confusion is common which is sad since a great deal of information is in the text but you virtually have to read the whole book to get it out. Nowhere can be found a clear account of the comprehensive management of acutely and chronically raised intracranial pressure.

The book lacks an authorative account of intracranial pressure measurement which I think one would have expected in a book published on this subject in 1978.

The clinical importance of the assessment of visual acuity and its preservation during the management of raised intracranial pressure are largely ignored. Since delayed treatment of raised intracranial pressure is one of the commonest causes of severe visual handicap in childhood the lack of space given to the subject is a major omission in the reviewer's opinion. It would have been helpful to include head circumference charts for premature babies. The account of valve systems is inadequate and the concept of shunt dependancy could have been more rigorously discussed. Craniostenosis is

mentioned at various points but an authorative account does not occur. A rigorous discussion of whether hydrocephalus is arrested does not occur and this is one of the commoner difficult problems faced by those managing children with raised pressure.

The place of CT scanning in the management of raised intracranial pressure should I think in a 1978 account have been fully integrated into the management of each section. In places it appears as an additional investigation.

This book therefore gives an interesting account of many paediatric neurological conditions which may cause raised intracranial pressure and I found it interesting to read. However, on the strict criteria outlined above, I do not feel that it can be recommended.

B. G. R. NEVILLE.

"Anaesthetics, Resuscitation and Intensive Care", by D. Campbell and A. Spence. Pp. 261. Price £5.00. Published by Churchill Livingstone.

This is the fifth edition of a book first published in 1965. It is written for students and residents wanting an introduction to anaesthetics. In this it succeeds by briefly illustrating the scientific basis upon which the anaesthetist is able to build up a clinical ability to serve the patient in many ways other than simply in the operating theatre. Because it is short, it is sensibly, and inevitably, dogmatic in parts but it also highlights some of the more common controversies. It is not, and does not intend to be, a pocket handbook for daily reference.

I am haunted by a feeling the book still remains a little outdated in its approach to some subjects (oxygen therapy for example) and because some commonly available drugs and items of equipment are omitted.

The most serious criticism is that it does not warrant "Intensive Care" in its title. It only attempts to cover respiratory intensive care, and that it does poorly. In a more light hearted vein—why is Guedel's hideous and useless diagram of the Stages of Anaesthesia still included in anaesthetic text books and how soon before authors cease to be bewitched by the "toggle mechanism" in an Adams valve and realise that these valves have long been superseded?

In summary I would recommend this as a very useful book, having a broad outlook on anaesthetics, to anyone approaching anaesthetics and its related activities for the first time.

M. B. BARNETT.
Dept. Anaesthetics.

"Exploring Child Behaviour: Basic Principles", by D. B. Helms and J. S. Turner. Pp. 388. Price £7.50. Published by Saunders, 1978.

The charming cover and attractive layout of text with delightful pictures seemed to promise an informative book on development and behaviour of children from birth to twelve years of age. Each chapter is divided into sections on physical and motor development, cognition and perception, and personality and social learning for various age groups arranged chronologically. There is also an "alternative topical contents" which gives a topic orientated sequence. Some topics are given more prominence and weight by the use of colour and different type. Every chapter ends in a neat summary and a short reading list.

It is disappointing that the authors in their attempt to cover this wide subject have presented a somewhat fragmented account of development. Relevant topics have sometimes been omitted, but what is perhaps more important, others of such great significance as the development of vision and hearing have been touched on only superficially.

The plethora of references to other studies does little to enlighten the reader or to develop the subject. Certainly a book for the interested parent rather than for the serious student.

D. F. EGAN.

Correspondence

News of R. F. H. Duncan

Sir,

Just recently a copy of the January 1979 issue of the *Gazette* came into my hands in which was the history of the Guy's rugby club of the 1920s.

I recognised the name of R. F. H. Duncan who played for Guy's in the early 20s and also for England.

It may be of interest for readers of the *Gazette* to know that at 83 years of age Hugh Duncan is still active, fit and well, and very much belying his 83 years.

He was the founder-president of the Rotary Club of Caversham, Reading and is to be seen regularly at their weekly meetings. He is not a subscriber to the *Gazette*, and was delighted to see the January issue which revived many happy memories.

He now lives in retirement in Purley near Reading and would be more than pleased to hear from any former colleague.

Yours sincerely,

J. BIRTWHISTLE

8 The Ridings,
Emmer Green,
Reading RG4 8NX
Tel: Reading 473489

The Churn

Sir,

Re H. Mather's letter about Milk Can

I also was at Vauxhall Station when the milk can was taken into the carriage of Curle, Hancock & Eccles and I was in the procession which followed it to the Spit.

Seventy years is a long time to remember events with accuracy.

J. R. BARROWCLOUGH
Guys 1907–1913

P.S. For your information one of Guy's librarians collected various accounts of the seizure of the milk can and although it was many years ago they varied even then according to a letter I had from him. I have forgotten the name of the Librarian.

I suppose you still call the college smoking room the SPIT?

Crescent Cottage,
Upwell,
Wisbech,
PE14 9DF

Guy's Hospital Medical and Dental Directories

Sir,

Your support for a new Medical Directory asserts that this may be purchased by the older members, but enquires whether it is the sort of publication that a graduate of the sixties or seventies would ever use. Combined with references to a "back-slapping camaraderie" it gives the impression that the practitioners' requirements of a Guy's Directory are not at all understood.

First and foremost we do not use the directory to look up our comrades or to "keep in touch". This would be an absurd use of the directory and would be no justification for the tremendous effort and expense which a good directory entails. The 1969 directory was a good directory because it was comprehensive. The current Dental Directory is regrettably a failure. I am aware of the amount of work, enquiries and dedication that went into this production. It fails because it seems that no one was aware as to how and why we use the directory. This is mainly for referral of patients—probably in the main of two categories. One category is for the patient who requires consultant advice either at Guy's or its satellites and the other is for a patient who is moving to another part of the country and therefore requires referral to a more accessible practitioner.

Many of my dental patients ask me for advice as to general systemic conditions and frequently the physician will ask for a suggestion as to an appropriate consultant. Because the new Guy's Directory has merely a list of names of practitioners it is no longer useful in this respect. The inclusion of the list of Guy's Medical and Dental Hospital Teaching Staff seems to be more absolutely essential and would have involved the minimum of trouble and enquiry. Perhaps it is not too late for an additional supple-

ment (only two or three pages) to be prepared and not only to be included with the directory, but to be forwarded to those existing purchasers who send in a request.

I stress here that no criticism is levelled against those who laboured under difficulties to produce this new Directory. Perhaps, Sir, the fault is ours for not stating our needs clearly until too late.

Yours truly,

JOHN O. FORREST, F.D.S.

6 Harcourt House,
19A Cavendish Square,
London, W1M 9AD.

Oversight Under Control

Sir,

We are grateful to Alex Milosevic (*Gazette*, 30th March) for his kind remarks about this year's finale at the Grosvenor House after Clinical Day.

Readily admitting the error of our ways, we apologise for the sad omission of a highlight which he and others eagerly awaited.

Having said that and without wishing to labour the point unduly but rather to set the record straight for any future archivist referring to the *Gazette* for historical information, I feel a little labouring is not out of order.

The first combined Dinner and Ball of the Dental Society as far as we can ascertain was held at the Grosvenor House in March, 1978. Any decisions regarding details of the 1977–78 programme were determined by the Management Committee for that year and not those who preceded them in 1976–77. This would account for decisions Alex does not recollect.

As far as the decision of this year's 1978–79 Committee is concerned, it was agreed unanimously that the format of the combined function was successful enough to warrant repeating it. However, we now realise that no Secretary's speech was perhaps an oversight we should not have repeated. Pity nobody mentioned it in 1978.

Even so it could hardly be labelled the Annual Report since the office would only have run threequarters of its term. On the other hand, Mr. Milosevic may feel this has certain advantages. It carries the guarantee that the shortest speech of the evening has to be cut even shorter—by another quarter at least!

MICHAEL MABERLEY,
President.

Toast for Tea

Sir,

The improvements publicized in "News-in-Brief" (February *Gazette*) to St. Christopher's hostel are generally regarded as a great improvement to the building both for the residents and, through the three new rooms for those whose financial responsibility St. Christopher's is.

However the plans conceived over four years ago and put into action without any consultation with the students who actually live there, have provided no space for an oven—a facility previously present and well used. We will however, we are assured, be able to cook at any one time no less than twenty pieces of toast!

The argument that the calibre of students residents at St. Christopher's are likely to *"destroy an oven in three months"* is certainly not reflected in the quality of the other fittings at present being installed. Neither is the replacement of one facility by another (a launderette) a reason for the increases in rent instigated four months before the improvements' were even begun.

Yours faithfully,

ALASDAIR JACKS
(Student Representative)

St. Christopher's
208 Long Lane,
London SE1

Arthur Hurst Centenary

Sir,

Arthur Hurst was among the greatest of Guy's Physicians and pre-eminent in this century. The centenary of his birth will be celebrated on 23rd July.

The British Society of Gastro-enterology has given some copies of the "Selected Works of A. F. Hurst", edited by Dr. Thomas Hunt, to the British Digestive Foundation. This gift is to help raise funds for the Hurst Memorial Fellowship which is being inaugurated as part of the centenary celebrations.

Those who wish to contribute to the Fellowship by purchasing a copy of the book, should send a cheque for £4.00 to me at 90 Alleyn Road, London SE21 8AH. Cheques should be made out to the *British Digestive Foundation.*

Yours faithfully,

PAMELA MANN

90 Alleyn Road,
London, SE21 8AH

Mrs. Ivy Gurry, the daughter of Dick and Flossie Bones, the Licensees of the Ship and Shovel, has kindly consented to our publishing a letter she wrote very recently.

"It was a lovely surprise to receive the Photograph of the "Doctors' Table" and a Drawing of the "Ship and Shovel". They brought back many memories, especially the Drawing, for that is how I remember the old "Ship" before the 'Blitz' and before it was partly rebuilt after being bombed.

"My Parents would have been most interested if they were still with us. Father passed away in 1963 at the age of 75 years, and Mother in 1969, aged 77 years.

"But there is one thing certain, and that is that some of the happiest days of their lives were spent in the company of the Medical Students and Doctors of Guy's Hospital, whilst licensees of the Ship and Shovel.

"My Mother spent many happy afternoons playing cards in the Saloon Bar (after closing time) with the "Boys", when I am sure they should have been elsewhere, studying. I can also remember many a "white" lie, we were asked to tell over the 'phone to sweethearts and lady friends, saying they not in the Doctors' Room and had not been in all day, whilst the guilty person continued on drinking with his fellow students.

"I rather gather that the College no longer stands, but I remember when it was a Residents' College, with two porters: Joe Johnson and Shipcott. "Ship" was a quiet, reserved type, while Joe was full of fun and laughter. Joe also acted as a Bookmaker's runner in his spare time, and during his lunch hour would come into the Bar to collect bets and pay out the lucky punters. Quite a few of the "boys" would have a bet, but I think my Father was Joe's best customer!

"They were indeed happy days and a lot of Fun. I wonder what happened to those boys?" But with the passing of time, and war between, it's hard to tell!"

The First Sighting of the Cuckoo

Sir,

I write to your most esteemed journal because with the no doubt temporary passing of the *Times*, I feel that my sighting of the first cuckoo on March 21st this year must not go unreported. With wide field and high resolution Mk. 2 Arco binoculars I saw the bird at 350 yards languishing on an elm branch in Ashburton Park.

I remain Sir, etc.,

ANNE T. DUDSLETT.

Guy's Hospital, SE1 9RT.

Ach So!

Sir,

All clinical students at Guy's will be familiar with the term "gauleiter" and most with its original German meaning [a chief official of a district under the Nazis] but I have yet to find the person who can explain its origin in this hospital.

Perhaps you or your readers could shed some light on when and how this "overbearing wielder of petty authority" was initiated at Guy's.

Yours faithfully,

WILLIAM CARLILE

Boland House,
Guy's Hospital,
London SE1

From the Communist Revolutionary Action Party

Sir

With horror, shame, and disgust the party secretariat heard of the passing of the notorious GHD FFC. While we despise bourgeois mediocrity and righteous complacency, we could not fail to see in the personage of Sir Adrian Weston a man who espoused the old system, but who was perhaps one of the few people in British Hospital Medicine who would have been capable of leading us into a true socialist revolution.

Sir Adrian has been accused, unfairly, of being incompetent, retrogressive and blundering. Our clever intelligence network has discovered positive proof that this slander campaign was perpetrated by the Central League for the Abolition of Minority Parties (C.L.A.M.P.) and further, that we are now in a position to name the leader at Guy's of this vicious, petty and vindictive little party. Indeed, we shall have no hesitation in doing so should they rear their ugly head in British Hospital Politics on any further occasion.

Sir Adrian's visage may no longer meander down the corridors of power at Guys, but let us hope that the memory of that figure will prevent the passing of other leaders of minority groups.

Yours ever ideologically,

Guys Communist Revolutionary Action Party

Harley Street
London, W.1.

Sport

SPORTS REPORT

With finals looming large on the horizon I regret that I am going to have to give up the job of sports editor after this month. Gary Calver will be taking over and I hope you will continue writing articles for him. I would like to thank everyone who has helped me make a Sports Section for the last two years. Also may I wish Gary the best of luck.

In the last five years at Guy's there has been a great improvement in sport. Our facilities are now of much higher standard thanks mainly to Eric and Joyce Dann who have renovated H.O.P. The new all-weather playing area and the new soccer pitch are very welcome and the work Eric and his staff have put into increasing the standard of the pitches has much improved them and benefited all the players.

However, it is no use having the facilities if you haven't the sportsmen and women. In the last five years there have been many people prepared to organise and arrange matches and many keen sportsmen who turned out regularly for Guy's and so the fortunes of the teams have been good. The Rugby Club is the biggest at Guy's and traditionally the most popular. In the last five years it has suffered mixed fortune. When I came to Guy's the club had seven or eight teams out every week. Three of these sides were "competitive" and the rest "social". The three competitive sides were arranged as a hierarchy and bore the flag for Guy's cup battles. The social sides were often rather secular and had extremely good players. With the removal of the status of all the social sides two years ago the club has only been putting out three or four sides a week and sometimes has trouble finding the players for these. The drop in interest in Rugby is a great shame and I think reflects the decreasing number of sportsmen at Guy's. All Guy's sportsmen play, leaving no supporters to watch and cheer. This lack of support is the most noticeable thing that has changed in the last fifty years and is illustrated perfectly in the History of Guy's Rugby Club by Mr. Lewis.

The Soccer club is rather closer to my own heart having played for five full seasons. Five years ago the club could manage one full team and half a second team that lost most matches. Now it fields three full teams every week and is thriving. The Hockey club is also doing very well the first team being promoted in two successive seasons.

However, although the state of sport at Guy's is quite healthy we are suffering badly from lack of sportsmen. With a scholastic system that needs high qualifications to enter the medical or dental schools the sportsmen unless he is innately intelligent will not get in. Over the past five years I have observed the differences between the sporting and the non-sporting students.

Sportsmen make very fine medical students and doctors. They are often very outgoing ambitious people who make an immediate rapport with their patients. They are in the main, efficient, confident and full of common sense. They will not often come top in exams as they prefer socialising and training for their sport but they usually have enough of a conscience to revise hard for exams and rarely fail due to lack of work. In summary the sportsman works and plays hard. I know of many non-sportsmen who because they prefer more solitary pursuits do not have the same skill in handling their patients although their working knowledge may include finer detail.

If this is so why should we fill our medical schools with hard working but introverted scholars when I believe that they need extroverts, characters and sportsmen. So let us bring an end to the ridiculous system of awarding places at Guy's and have more interviews where a truer assessment of a student can be made. I think Guy's should rely less on a candidate's qualifications than on whether he will add spice to life at this establishment. After all is said and done which is Guy's Hospital remembered for —its MBBS passes or its Rugby teams?

So let us have more sportsmen at Guy's so that the progress of the last five years is not wasted and Guy's sport may strengthen and expand.

JONOTHAN EARNSHAW

1979 SOCCER CLUB GERMANY TOUR

This tour was the first venture of the Soccer Club abroad for six years. Meticulous planning chiefly by Andy Mitchell and careful saving of our pennies meant that this year we were able to invade the European mainland. The tour was a great success but lack of space prevents a detailed account.

The tour started with the team meeting one and a half hours late, however we just made the ferry. Soon we were speeding through Northern France and Belgium, until the van broke down. However Ian Wilson and Simon Perkins (the 1979 European kerb hitter of the year) dragged a friendly Belgian mechanic from his glass of vin and 3½ cold hours later cheered by Belgian friendliness and under certain opinions about British engines, we continued. The rest of the night was spent trying to sleep (Keith Underwood seemed to have no problem) and crossing through borders without being stopped. There's a wayside chip-stall in Luxembourg that will never be quite the same again! We reached Germany where our passports were rigorously scrutinised, especially Dave Green's whose photo seemed to have grown a goatee beard and a pair of horns (he was known thereafter as Satan!). We finally arrived at Landstuhl at 5 a.m. to be greeted by Andy's father with beer and sandwiches. We slept on campbeds in a large common room and nobody stirred until 10.30 when the windows were opened very quickly. The early afternoon was spent being shown round the U.S. Army hospital at Landstuhl by Colonel Tyrell who was justly proud of his hospital—the largest U.S. hospital in Europe.

Later that afternoon we played Saarbrücken University. We played on an unfamiliar shale pitch against a team we later learned are one of the best amateur sides in Germany. We lost. It was a shame really because Saarbrücken had a lot of support, and the local newspaper and TV reporters had come along. However after the match we showed the Germans how to sing after consuming vast quantities of sandwiches . . . and beer. One sad part of the match was that Ken Harper broke his ankle in the first 20 minutes and didn't play again on tour. The next day we played the American Army base at Landstuhl on a mud pitch. The team didn't play well but nevertheless ran out 5—0 victors. The opposition were once again impressed by our singing prowess. The evening was spent in Mr. and Mrs. Mitchell's flat where an excellent meal and much wine was consumed. There's no one that can embarrass you like a mother, is there Andy?

Sunday was the "rest" day and the team went sightseeing at Heidelberg, with the exception of Simon Perkins who was suffering from an overdose of chocolate. The day was fairly uneventful apart from a short drive down a pedestrian precinct and an hour and a half traffic jam because of an autobahn accident.

Monday followed a sober night and we journeyed north ot Rheindahlen up the Rhine valley interrupted only by a further breakdown, and the motorway interchange at Cologne which makes sphaghetti junction look like a T-junction. We got lost! However we arrived at the R.A.F./Army base at 9.30 and were met by Flt/Lt. Jimmy Miller. We swiftly unpacked and headed for the nearest bar to be met by the U.K. R.E.M.E. and R.E.M.E. Germany Rugby teams demanding to meet the Guy's Rugby team; things were hastily explained and a nasty situation avoided, 'cause they were *Big*.

The next morning saw a seven o'clock reveille Breakfast in the mess was followed by Jimmy and his sidekick Roger taking us to the RAF hospital at Weg-Berg. Wing-Commander Livingstone gave us a tour of the hospital and was extremely friendly, even when he was run down by Ken Harper's wheelchair pushed by Gary Calver. The tour was finished in the hospital bar, we were then plied with food in the Mess before being taken to R.A.F. Germany's ground. Guy's played very well in the first hour of the match, Mike Breeze hitting the bar early on. However the previous week's excess began to tell especially combined with our unfitness and the R.A.F. with some superb finishing scored four times in the last 30 minutes to win 5—0. Unfortunately John Rawcliffe and Harry Williams joined the injury list with Ken Harper. The rest of the evening was spent entertaining and being entertained by the R.A.F. in the Dutch bar and other places. Greg Tamlyn proved he is tough by repeatedly demonstrating his heading ability on concrete.

The next morning saw another seven o'clock reveille followed by a browse round the largest NAAFI in the world. Early in the afternoon we went to play the British Army of the Rhine and there again we played well for an hour although innumerable chances were missed. When Dave Smalley pulled one back in the second half to make it 3—1 Guy's seemed still to be in with a chance but once again our unfitness told and Guy's eventually lost 7—1.

After a quick beer and fish and chips to speed us on our way we bade goodbye to Mr. Mitchell and set off for Ostend. We arrived half an hour before the ferry sailed without too much mishap but only just managed to scramble onto the last space. On the ferry we pooled our remaining pfennings for bottles of beer at astronomical prices finally arriving at Dover at 3.30 a.m. We smuggled 30 cases of scotch, 50,000 cigarettes, 25 Pakistanis and Dave Green through Customs, and set off for home and Guy's.

We sang our way back arriving at 5 o'clock very tired but satisfied at having spent a good tour together.

The team, I think, learnt much from playing abroad and also made many friends, all of which I think bodes well for the future of the club.

The Tour Party would like to thank Mr. and Mrs. Mitchell very much indeed for their hospitality; and also Andy for organising the tour. Further thanks must also go to the R.A.F. for their hospitality and lastly thanks to Simon Perkins and Dave Smalley for doing a grand job driving us there and back. Keep hitting those kerbs Simon!
P.S. Regards to H.W.'s sister.

Tour Party: Robin Evans, Ken Harper, Harry Williams, Gary Calver, Gerry Hackett, Dave Abraham, Andy Mitchell, Dave Green, Dave Smalley, Simon Perkins, Greg Tamlyn, Ian Wilson, John Rawcliffe, Keith Underwood and Mike Breeze.

G. C.

SOCCER

U.H. Soccer Cup Final

Guy's II 1, Bart's II 2

Half-time—Guy's one up in the blizzard.

The sun came out for the first time in 1979 to shine on London, raising the hopes of Guy's second soccer team. This was the fourth Cup Final played by the team in as many years and the previous three had all resulted in losses. Many of the players appearing had played in all three previous finals and thus hopes were running high. With the powerful London Hospital knocked out, the opposition for this final at Teddington came from Bart's.

The game started in bright sunshine and Guy's responded with tight, controlled soccer. They were challenging excellently and winning much of the

midfield ball and wingers Underwood and Rawcliffe were spraying centres over. Several corners and free kicks were forced by this sparkling Guy's side but their finishing never quite matched their tenacious approach work.

Bart's, although cornered in their own half for much of the first half, made several quick breaks and the defence including Abraham tackling like a bulldozer were forced into sharp clearances. 'Keeper Nick Cowland rescued the Guy's team, hell bent on attack, a couple of times. He has had an excellent season and his confidence is much improved. He made two superb saves in the first hal one a brilliant leap to his right from a fiercely struck free-kick. At the other end the Bart's 'keeper was well positioned to save an Earnshaw header from an accurate cross by Rawcliffe.

As Guy's pace slackened, Bart's started to work their way into the game. Suddenly the skies clouded and a blizzard of sleet and snow started which made playing conditions impossible, A minute before half-time Guy's were given a free-kick on the halfway line. Greenaway floated an inch perfect cross to the far post where Earnshaw in his last game for Guy's and his third cup final powered a header into the net.

A jubilant Guy's sucked their half-time oranges in the blizzard but in the second half all was to turn sour. Guy's tackling and aggression that was so much the difference between the teams in the first half went soft and Bart's fought back to equalise after ten minutes. Swiftly Ostlere, that old Bart's campaigner, brilliantly took a half chance and scored to leave Guy's a goal down. With half an hour now to go and all to play for captain Davies came on as substitute but all his and vice-captain Harri William's exhortations could not raise the Guy's game. Although they attacked solidly, Guy's seemed bereft of ideas and never really looked like getting back on terms. A great shame for a team who have played well together for quite a time and whose best ever chance of lifting the cup was this year. So Bart's ran out 2—1 winners after a close game.

Once again a coachload of Guy's supporters provided a barrage of noise mixing encouragement with abuse and lifting the team considerably. To these students many, many thanks—one year we will win the cup for you!

The aftermatch celebrations were raucous as usual. The boat race was summarily won in style and so honour was restored.

The 20 stone coach-driver was running around naked, the hoarse supporters sang on and Greenaway lost his trousers and spilled his beer. He was to do both these frequently throughout the evening.

So until next year Guy's are second again but no one seemed dispirited including those marvellous supporters—well done to all.

J. J. E.

MEN'S SQUASH

The huge success of the U.H. Cup is well documented below.

The Men's K.O. Tournament took place in the second half of the season and despite several walk-overs, Colin Holden met Jamie Farquharson in the final and won 3—1.

The regular teams haven't managed to do nearly as well as the U.H. Cup team. The friendly matches (Guy's Gonads) came out with an almost perfect balance of 12 wins and 10 losses.

L1 came top of Division I of the University of London Squash League in the first half of the season, something that hasn't happened for some years, but then managed somehow to come bottom in the second half, due mainly to the regular players going away on holidays, electives, etc. People playing for L.I. include D. Webber, C. Holden, J. Farquharson, V. Tun, A. Morgan, M. Yaffé, J. Pringle, P. Evans.

L2 seemed to have a strong enough team to do well in Division 2 but only came seventh in the first half and bottom (10th) in the second. Again the problem seemed to be a lack of a regular team with a stable pool of players. Team players include A. Morgan, S. des Clayes, T. Thurston, M. Yaffé, J. Pringle, N. Higgins, J. Murch and R. Sharp !?!

L3 was reinstated into the L.U.S.L. in the second half in Division 5, and has done reasonably well, not because it was withdrawn from Division 3 last year but more because five points were offered on a plate on several occasions when opponents didn't turn up. The team is for the encouragement and advancement of young or new squash players. Unfortunately I can only remember the following playing for this team: J. Murch, T. Thurston, R. Trounce, D. Hett and the others I've missed. Sorry.

The Cumberland Cup team seem doomed to relegation to Division 4 of the Cup despite the talents of D. Tanke and P. Evans newly added to the main squad of D. Webber, C. Holden, P. Collins, J. Farquharson and V. Tun.

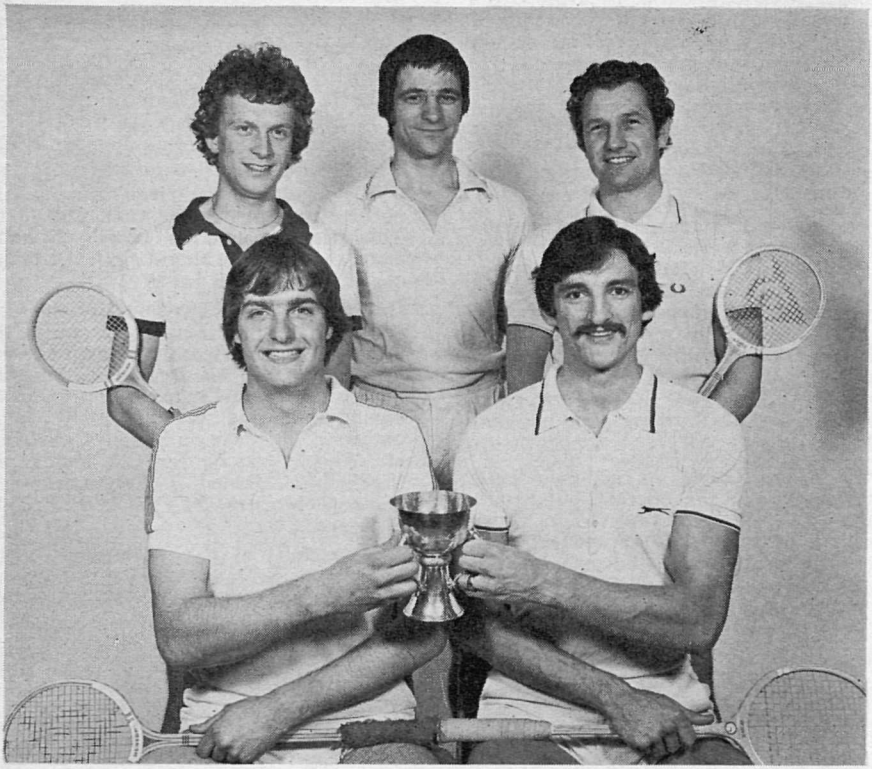
Since I've ended on such a gloomy note perhaps I can appeal to any squash players to play for the teams and turn up to the training sessions at the beginning of next season. Remember, Your Hospital Needs You!

N.B. A.G.M. at 5.30 p.m. on Thursday, 3rd May in B.H. Committee Room.

V. T.

INTER HOSPITAL'S CUP COMPETITION

RUNNERS UP 1978
WINNERS 1979



J. FARQUHARSON(Capt.) R. LEWIS R. SHARP

D. WEBBER C. HOLDEN

Inter-hospitals Knock-out Competition 1979

Following last year's hotly contested competition and a disappointing (3—2) defeat against St. Mary's in the final, the members of Guy's team were keen to correct the result this year. The team being essentially the same as last year's "participated" in fairly regular training prior to the competition and although the standard of play was about the same, if not a little higher than last year, the team spirit was a lot higher.

We received a bye into the second round, where our first match was against St. Thomas's, who we played at home.

Gazette Prints

The *Gazette* has produced full-size photo-facsimiles of three pen and ink drawings by Hanslip Fletcher of Guy's Hospital and its environs, on matt-finish high quality paper suitable for framing.

(a)	**The Medical School 1947**	**Size 15 in. x 12 in.**	**£5.00**
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(c)	**The "Ship and Shovel" 1912**	**Size 10 in. x 8 in.**	**£2.50**

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To : The Manager, *Guy's Gazette*, 16 St. Thomas Street SE1 9RT.

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This match was potentially a difficult one, but all members came through fairly comfortably to give Guy's a (5—0) win. Apart from taking us through to the next round, this result certainly boosted any faltering confidence and meant we were to meet the London Hospital in the next round. Although we won this match (3—1) (one of the rubbers was not played), the individual matches were of a high standard and not as easy as the score might suggest. Winning this match took us into the final again, and again we found ourselves playing St. Mary's.

Prior to this match additional training sessions were arranged and lengthy discussions as to both individual and team tactics followed. "Fiddling" the order is difficult against St. Mary's as their order invariably "changes" on the day. However, we played our strongest order, and because our standard is fairly uniform, our strength was in depth. The match was played on neutral ground at St. George's. Colin Holden and Jamie Farquharson playing at three and five started. Both determined to establish a good team position, won without too much difficulty. Colin, with good match temperament and fitness, played a tight game with few mistakes, and proceeded to win (3—0) easily. Jamie played with determination and although bad bounces and calls were given because of the poor plaster on the front wall he too had a comfortable (3—0) win. Roger Lewis and Ray Sharpe playing at four and one played next. Roger (keen to recitfy his 10—9 defeat in the fifth last year), proceeded to run for his usual five setter match. In front of a packed gallery he played fine squash, but had a tough game on his hands, and despite good volleying and boasting went down (3—1).

Ray, whose stylish tracksuit and kit won him the first few points, played his characteristic competitive way and by taking the ball early and leaving nothing had some long rallies which appeared to tire his opponent. Taking advantage of this he went on to win (3—0). A sigh of relief went up from the Guy's supporters, and a somewhat Mary's-packed gallery seemed a little disappointed. The match had already been won when Dave Webber, at two, began. Unfortunately Dave had a difficult match against a player who seemed to be out of position(?). However, it was a well contested match and Dave's unorthodox kit didn't affect his opponent, who went on to win (3—0).

Guy's (3—2) win over St. Mary's was certainly a much deserved result, and although it is not certain when Guy's last won the "Interhospital's Cup", it was quite some years ago.

Reckitt-Colman Ltd., who sponsored the tournament, provided drinks and a cold buffet after the match which was much enjoyed. This was followed by the presentation of the cup and a short speech by the winning captain. Congratulations are in order to the members of the team, who I know will be determined to retain the cup next year.

Team: R. Sharpe, D. Webber, C. Holden, R. Lewis, J. Farquharson.

Jamie Farquharson

HOCKEY

GUY'S GIRLS UNLUCKY TO LOSE

On Sunday, 11th March, Guy's Ladies' Hockey Club played Chelsea in the final of the U.L. Cup. They assembled on an overcast day at Motspur Park along with a motley band of boyfriends, parents and others in the guise of supporters, sadly outnumbered 3:1 by the Chelsea crowd.

The Guy's team led by Kristin Pagaus started nervously and even with the Guy's supporters outshouting the Chelsea contingent (although one Guy's man was struck dumb by the variety of Chelsea underwear) our team was soon under pressure. Chelsea, taking advantage of this and Guy's hesitancy, soon went ahead—scoring three times in the first twenty minutes. The first took a deflection into the roof of the net (unlucky Sian); the second entered the net via a foot not spotted by the umpire and the third was a skilful move well worked by Chelsea. Guy's however were stirred onto greater things and with Clare and Wendy-Jane on the wings playing well Guy's were soon on top, but even after a series of short corners Guy's failed to score.

Half-time then came with Guy's still three down, but refreshed by oranges (the largest seen by a Guy's team for a while) and full of good(?) advice from the spectators Guy's returned to the field in good spirits.

The second half started evenly with Chelsea recovering from their pre half-time lethargy. However prompted by Julie, Kristin and Sally in midfield Guy's began their fight back. The Guy's girls being stirred onto greater things by the disappearance of some of their supporters as the bar opened. Now seeing more of the ball the Guy's attack of Elaine, Cathy and Angela began making inroads into the Chelsea defence. A goal soon followed, when following a cross by Clare, Cathy slipped the ball to Elaine who keeping her head, put it in.

Guy's were only denied a quick second goal by the failure of the umpire to play advantage. However Guy's did score again soon after through Cathy combining skill and tenacity to put the ball home.

Chelsea at this stage were under severe pressure shown by some nasty tackling resulting in one of their team being warned by the umpire. The few breakaway attacks Chelsea did have were ably dealt with by Debbie, Sian and Helen.

Guy's continued the pressure (encouraged by the rest of their supporters, suitably refreshed) until the final whistle, but unfortunately were unable to capitalise on it.

It was a good performance by Guy's who were unlucky to lose. It was a shame that there was not more support—what better way to spend a Sunday lunchtime than watching 22 healthy young girls (in short skirts) fighting for the honour of Guy's especially when the bar was open.

Not only were Guy's robbed of a result but Chelsea also stole Sally's dog Sibelius.

The team would wish to thank Kristin for the hard work she has put in throughout the season and especially for the Cup Final.

Team: Helen Wright, Sian Thomas, Debbie Uwins, Sally Clarke, Julie Sanderson, Kristin Pegaus, Clare Wheeler, Elaine Dare, Cathy Irwin, Angela McCluckie, Wendy-Jane Stevenson.

G. D. C.

Hospital Information

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CAZENOVE MEDALS FOR 1978-79

Cazenove Gold Medal—Mrs. Caroline Claire Kingdon.

Cazenove Silver Medal—Miss Carol Jean Carter

Cazenove Bronze Medal—Mrs. Karen Michelle Russell.

PERSONAL

CONGRATULATIONS to Mr. R. J. Cann on the occasion of his Golden Wedding, from hundreds of Guy's men and women who enjoyed his friendship and benefited from his skills and his teaching during his years at Guy's.

SIXTEEN year old daughter of French Medical Professor wishes to stay as a paying guest in similar British family for three weeks in July, in order to improve her English. Replies. Box No. 1/4 Gazette Office.

CHANGES OF ADDRESS

GENT, Mr. & Mrs. A. P. W., (Nee A. E. J. Moore), 179 Evington Lane, Leicester, LE5 6DH. Telephone: 737814.

CHENEY, G. T., Esq. RD, MB, BS, FDS, RCS, Grange Meadow, Low Road, Tasburgh, Norwich, NR15 1AR.

MAY, Mr. C. D., BDS, LDS, RCS, 16 Church Green, Hersham, Surrey.

DEATHS

CONYBEARE, Dr. Ernest Thomas. We regret to announce the death of Dr. Conybeare on April 2nd and will be publishing a full Obituary in due course.

MEADOWS, Dr. Guy Meadows of 12 Hardy Road, Bridport, Devon, who qualified MRCS, LRCP, 1918.

WALKER, Mr. F. A., FDS, RCS of 2 Cresswick, Whitwell, Nr. Hitchin, Herts. Died Peacefully in Hospital aged 79 years on April 7th.

Guy's Hospital Dental Directory

A new edition of the Dental Directory is now available to our dental subscribers, containing up-to-date alphabetical and locality lists of Guy's practitioners.

Available from the Sub-Dean of Dental Studies, Medical School, Guy's Hospital, London, SE1 9RT.
Cost £1.25 (inc. postage within U.K.)

Cheques to be made payable to Guy's Hospital Medical School.

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NURSING CORRESPONDENT — JULIA FABRICIUS
PHYSIOTHERAPY CORRESPONDENT — RONALD COOPER
MANAGER — PAT POULTER

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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26 MAY 1979 VOLUME 94 NUMBER 2292

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Passim

Less Administration — More Cash

We offer our heartiest congratulations to Dr. Gerard Vaughan, Consultant in the Department of Child Psychiatry, upon his recent ministerial appointment. We hope that Dr. Vaughan will spare a thought for us here at Guy's, where the Hospital and Medical School seem emperilled from both the Resource Allocation Working Party and the Flowers Committee (see *Clubs' Union News*). We live with the continuous threat of being scuppered between this veritable Scylla and Charybdis!

Dr. Vaughan and his Conservative colleagues have a splendid opportunity to restore morale to "the centres of excellence" and to a sad and divided National Health Service.

That a fair society is run according to the utilitarian principle of the greatest good for the greatest numbers is, perhaps understandably, deeply embellished in western thinking. When he addressed the Quodlibet Society, Arthur Scargill argued that he saw little wrong with the acquisition of wealth by capitalism but that the vexing issue was just how this wealth should be distributed. The most obvious utilitarian solution to reduce underprivilege is to divide fairly **whatever** resources we have. Quite what constitutes fairness is another matter but this does not really detract from the appeal of a Robin Hood's altruism. However, our leaders have often considered that underprivilege can be remedied by tapping off and redistributing within society, without precise definition of either terms.

The ratio of doctors and dentists to lower socio-economic groups is less favourable than to the more affluent, and in this *London and its environs are by no means excluded.* It does not follow that the remedy is to re-site centres of training and research, because we are not the rich from whom a government can take to give to the poor. Furthermore, we must continue to expand, for stasis only invites decay.

With a miserly 5.4% of the G.N.P. allowed for health, deficiencies are only to be expected. The solution is really quite simple; less administration and more cash, with medical staff having a better say in *how* and *where* it should be spent.

We hope that the new Government will maintain what is outstanding in the Health Service and not close, cutback and redistribute because of some over-literal interpretation of egalitarian dogma.

cc. Mrs. Thatcher and Dr. Vaughan

Jon Earnshaw

We are particularly sad to be losing this month Jon Earnshaw, who has most ably edited our sporting columns since April 1978. Jon has felt very strongly that sport has increasingly been denied its traditional pre-eminence in the life of Guy's and has written of this in no uncertain terms. Although he probably views himself as the last of a dying breed of Guy's men, the Editors suspect that his talented successor *(vide infra)* will prove that the dodo is not yet extinct. We wish Jon every success and happiness in his future career.

News in Brief

Dr. P. R. C. Evans

We offer our best wishes to Dr. Philip Evans, G.M., M.D., F.R.C.P. upon his retirement, after more than thirty years of service to the Wrexham Group of Hospitals.

Consultant appointment

Our congratulations to Mr. John D'Arcy, Senior Registrar in Orthopaedics, who has been appointed Consultant Orthopaedic Surgeon at Eastbourne District General Hospital.

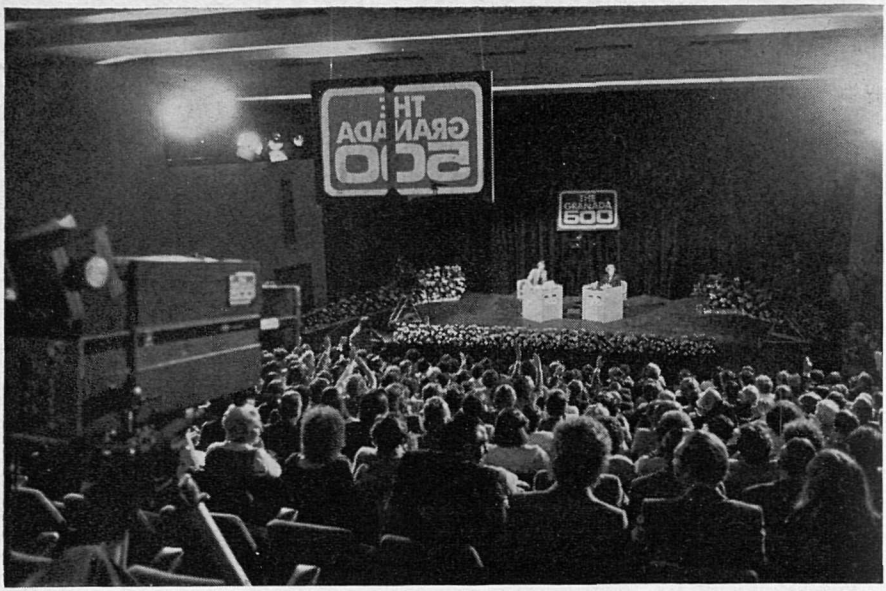
Former Guy's trainee wins nursing scholarship

Our congratulations to Mrs. Judith Mackie (née Butterworth) S.R.N., who trained at Guy's and is one of 19 nurses from all over Britain who shared £20,000 in Hospital Saving Association (H.S.A.) Scholarships this year.

Awarded annually by the Association's Charitable Trust, the scholarships are in recognition of the care received in hospitals by H.S.A. contributors and their families. They enable graduate nurses to obtain more advanced qualifications and to pass on their knowledge to others.

Mrs. Mackie, now Senior Nursing Sister in the Cardiac Surgery Department of University Hospital, Cardiff, intends to study for part B of the Diploma of Nursing at the Royal College of Nursing, who co-operate with the Hospital Saving Association in judging the candidates.

Party leaders visit Guy's



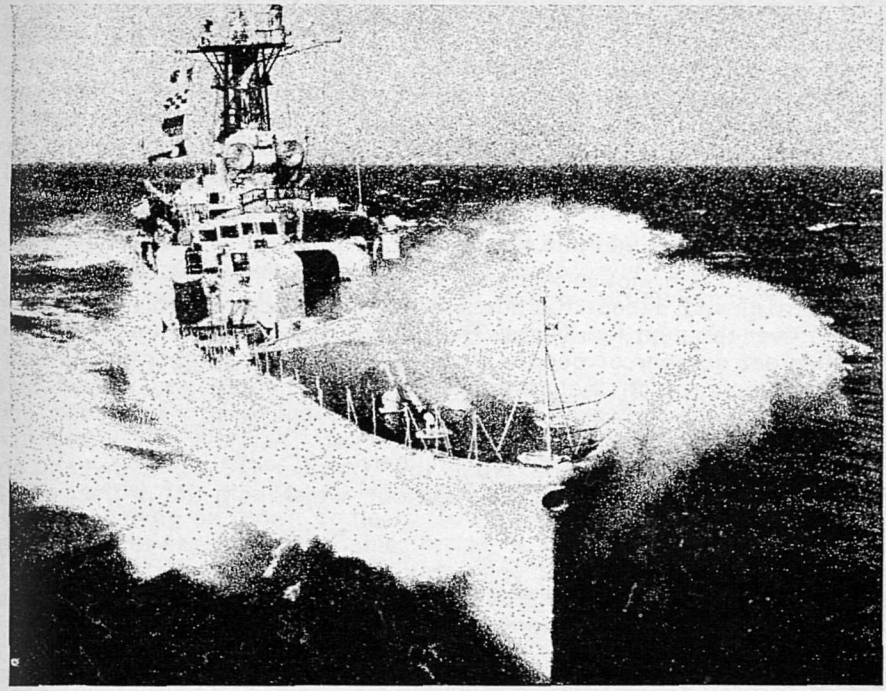
Margaret Thatcher being interviewed in the Greenwood Theatre at Guy's Hospital.

The constituents of Bolton East have voted with the winning party in every election since the Second World War. This year on April 30th 406 constituents from Bolton East came to the Greenwood Theatre to put questions separately to the leaders of the Conservative, Labour and Liberal parties.

The meeting was later televised by Granada but despite such publicity the Bolton East constituents failed to vote with the winning party—they returned the Labour candidate with a majority of about 1,000.

Alcohol Conference

A group of Guy's medical students attended a national Symposium on alcohol and alcoholism organised by the Medical Council on Alcoholism at the Royal College of Physicians on April 27th. The Symposium was chaired by Sir Dick Caldwell and after opening remarks by Lord Porritt four papers were presented covering various aspects of this growing problem. The Guy's contingent made a positive contribution to the discussion groups in the afternoon and most found it a worthwhile event. The Guy's presence was organised by the Student Medical Education Committee with the co-operation of the Department of Psychiatry.



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ROYAL NAVY MEDICAL CADETSHIP

Thamesmead Open Day

The Lakeside Health Centre at Thamesmead in south-east London, which has close teaching connections with Guy's, held a successful Open Day on May 3rd. A large group of distinguished guests were able to "sit in" on the daily activities at Lakeside and its sister health centre, Gallions Reach. The two health centres provide general practice experience for Guy's medical students, which emphasises active participation in the running of routine surgeries and patient interviewing.

Wolfson House Appeal Fund closes

The Wolfson House Appeal Fund has now reached its target and has been closed except for sums which have been promised or covenanted over the next few years. The School remains enormously grateful to the great number of people who in one way or another have contributed to the project, including all those Guy's men and women who have given money towards the cost. The School owes a particular debt to the Wolfson Foundation, the Dunhill Trust, The Hayward Foundation, the J. B. Rubens Charitable Trust, the Ultramar Oil Company and the Special Trustees of the Hospital, without whose help the project would not have succeeded.

Guy's student discovers lost shark

The shark's tooth now in the National Collection. Approx. x 2.

Guy's Medical Student and amateur palaeontologist Alasdair Jacks made an unusual discovery when fossil hunting at Barton-on-Sea, Hampshire, recently. He unearthed the tooth of a species of prehistoric shark never before recorded in the United Kingdom. The British Museum (Natural History) said that the shark was known from the Eocene deposits of North America. A spokesman said they hadn't the foggiest idea of how it ended up on the beach near Bournemouth some 50 million years ago. He added, *"This is something of a mystery"*. The primeval puzzle has been presented to the National Collection.

Progress Report on Development Works

We are pleased to report that work is nearing completion on the **Cardiac Catheterization Suite, the Gastro-Enterology/E.C.G./Drugs Information Unit** and **Block 11 of New Cross Hospital.**

The **Intermittent Dialysis Unit** has returned to Bostock House and it is hoped to re-commission Sarah Ward in June 1980, in its new function as a 5-day ward.

Work is now in progress on the new building to house the **Bloomfield Department of Child and Adolescent Psychiatry**—completion date is set for May 1980.

The **Special Trustees** have moved into Mary Sheridan House, 11-19 St. Thomas' Street and other users will be following over the next 3 months.

The Friends of Guy's Hospital A.G.M.

Officers and friends gathered on Wednesday, 2nd May for their seventh A.G.M. preceded by an excellent lunch in the Robens Suite.

The guest speaker this year was Dr. R. Buckman, well known in his role in the *Pink Medicine Show*, who gave a characteristically amusing account of why he didn't come to Guy's, although he is a cousin of the revered personage of Stephanie Amiel, a past editor of the *Gazette*. After delivering his well received speech, Dr. Buckman drew the winners of the 1979 Super Raffle. He was clearly eager to know more of the "Heated Sideboard Hostess", thought the Antler shoulder bag thoroughly appropriate to our sunny climes and saw a cosy future for the two travelling rugs—the English version of the Flying Carpet perhaps?

PRIZE WINNERS OF THE SUPER RAFFLE 1979
Tickets drawn at the Annual General Meeting by Dr. R. Buckman, M.R.C.P.

		Ticket No.	*Name and Address*
1st Prize	Luxury Holiday for 2—1 week in Victoria Hotel, Sidmouth, Devon.	04318	Nancy O'Brian, The Turrets, London, N.11.
2nd Prize	Black and white portable ALBA Television Set	09122	E. Welch, 32 Matson House, Bermondsey, London SE16 2ES.
3rd Prize	Sunbeam Food Mixer with attachments	05867	R. Drury, 295 Hythe Road, Willesborough, Ashford, Kent.
4th Prize	Goblin Teasmade	06279	Mr. Ryan, 25 Ashley Gardens, Palmers Green, London NW.
5th Prize	Heated Sideboard Hostess	06330	M. Wainwright, 22 Ongar Close, Camberwell, London.

6th Prize	Grundig Portable Radio	06776	Peter Gillman
7th Prize	Russell Hobbs Toaster	00896	Mrs. E. M. Hutton, 01-789 5217
8th Prize	Antler Shoulder Bag	04201	Mr. P. Freeman, Squash Welling, Station Approach, Welling, Kent.
9th Prize	Pifco Mini Boiler	03228	Justin Mills, 157 Upton Road, Bexleyheath, Kent.
10th Prize	Glass Dessert Set	07701	Mrs. Bearfield, Price, Waterhouse & Co. Print Room.
11th Prize	Travelling Rug	09012	Gibbons, 20 Harper Road, London, S.E.1.
12th Prize	Glass Mugs	01271	Miss J. Worsfield, Thistledown, Orestan Lane, Effingham, Surrey.
13th Prize	Travelling Rug	03445	Mr. C. A. Keogh, 79D Sunderland Road, Forest Hill, London, S.E.23.

No Card Game

Mr. Stanley Evans, security officer at Guy's, is deeply concerned at the growing number of thefts and acts of vandalism in the hospital, perpetrated by young teenagers. Over 40 incidents have already been reported this year, including the theft of wallets, handbags and signposts and the daubing of the ubiquitous indelible graffiti.

A new scheme has been proposed, whereby all hospital staff and students be provided with an identity card, probably carrying a photograph. This manoeuvre would probably be supplemented by an increase in the number of security personnel. But as Sergeant Ford of Southwark Police reminds us— *"Carelessness of staff and patients is greatly to blame . . ."*

Gazette Staff Appointments

We welcome Mr. William van't Hoff and Mr. Mark Powlson as News Editors this month, and Mr. Gary Calver as our Sports Correspondent. William van't Hoff is a preclinical medical student and an active member of the Student Medical Education Committee. Mark Powlson at present completing his B.Sc. course in the Physiology Department, is Vice President of the Clubs' Union and a past contributor to *Tablet,* the fortnightly news sheet. Gary Calver, a senior clinical medical student and stalwart of the soccer team, is set to spearhead the renaissance of the sporting ethic at Guy's and as such needs no further recommendation. We look forward to a long and happy association.

About this month's cover

This month's cover shows the Medical Wards and College of Guy's Hospital in 1912, from a drawing by Hanslip Fletcher. A signed copy hangs in the Wills Library.

South Wales and Monmouthshire Guy's Society

Left to right :

Standing

Dr. Bertie Webb, Mr. Morwent Brown, Mr. Hugh Kinder, Mr. Reggie Hoar (Pres.), Dr. Kenneth Maclean, Dr. Myrddin Davies (Pres. Elect), Dr. Tony Thomas.

Seated

Mr. Chris Lewis (Hon. Sec.), Mr. Gary Lewis (Hon. Treas.).

Dates from the Medical Diary

June

Fri. *1* Entries close for the Leonard Lubbock Prize in Chemical Pathology.

Mon. *4* M.B., B.S. (Revised Regulations) Examinations begin. M.B., B.Chir. (Cambridge) Examinations may begin this week.

Wed. *6* Examination for the Leonard Lubbock Prize in Chemical Pathology begins.

Fri. *8* Entries close for the Leslie Hillman Prize in Haematology.

Wed. *13* Examination for the Leslie Hillman Prize in Haematology begins.

Fri. *15* Entries close for the Golding Bird Medal and Prize in Bacteriology.

Mon. *18* Preliminary Examination for Studies in Medical Subjects begins.

Wed. 20 Examination for the Golding Bird Medal and Prize in Bacteriology begins.

Mon. 25 Final Conjoint Examination begins.

Fri. 29 Entry forms for Final M.B., B.S. (Old Regulations). Examinations in October must be left in the Medical School Office by this date.
Essays for the T. J. Evans Prize must be handed into the Medical School Office by this date.

Dates from the Dental Diary

June

Fri. 8 Written paper for the David Frank Sturdee Prize in Prosthetic Dentistry and the Properties of Dental Materials.

Mon. 11 N.B. Second B.D.S. Examination may begin this week.

Mon. 18 Third B.D.S. Examination, Parts I, II, III, IV and V begins.

Mon. 18 N.B. Preliminary Examination for Studies in Medical Subjects may begin this week.

Fri. 29 Essays for the T. J. Evans Prize must be handed into the Medical School Office by this date.

Clubs' Union News

Grants increase

One important item of news that effects all Guy's Medical and Dental students is the rise in student grants that will come into effect on September 1st, 1979. The rise is approximately 13% on the 1977/78 figure. Scales for the full grant for students living in halls of residence or lodgings are given below:

	from	to	increase	%
	£	£	£	
Preclinical (33 wks.)	1397.65	**1579.50**	**181.85**	13.01
B.Sc. (40 wks.)	1590.50	**1800.00**	**209.50**	13.17
Clinical (45-50 wks.)	1921.10	**2178.00**	**256.90**	13.37

The grant for students living at their parental home is also increased by a comparable amount. In addition the minimum grant has been increased to £335. The scale of parental contribution to the student's grant has been revised, one consequence of which is that the minimum parental residual income at which contribution is exacted has increased from £3800 to £4700.

Flowers Committee

I should like to remind you about the possible consequences of the deliberations of the Flowers Committee for Medical and Dental Education in London. This Committee was set up by Lord Annan, the Vice Chancellor of the University of London, to examine the London Schools situation in view of the effective reduction of financial support that they

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enjoy, because of the trend for the reallocation of N.H.S. staff (who also teach clinical students) outside of London.

Though the working party cannot make recommendations with regard to N.H.S. hospitals, there is little doubt that the conclusions of the group will be greatly influenced by the D.H.S.S. policy of reducing the amount of money going to the London Hospitals, following the advice of the Resource Allocation Working Party (R.A.W.P.). The scale of savings necessary may well mean the closure of one of the London medical schools. However, the University will continue to train as many doctors and dentists as before, nor will the gross sum of money allocated to the Faculty of Medicine be reduced should this move really come about. So the University would not in fact *"save"* money but it would not have to shoulder any larger proportion of the costs of teaching clinical students.

The potential importance of this to Guy's and to the quality of medical education in London is obvious. Needless to say different schools have reacted with very different degrees of paranoia to the working party's request for evidence, but I suspect that if the committee does recommend the closure of a school then Guy's is not top of the list. There is of course an alternative which is that all the London Schools be reorganised, so that by amalgamating some departments and by a general policy of pruning, the cutback could be shared out among the 12 general medical, 5 general dental and 15 purely post-graduate institutions in the University.

The University of London Union Medical Group, in which your Guy's representatives play an active part, has accepted the working party's invitation to all interested organisations and individuals to submit evidence. We think at this moment in the evolution of medical education in London that there are some crucial educational principles which ought to be considered as part and parcel of the committee's eventual recommendations. To bring this to their attention we are in the process of preparing a document which sets out our views.

The future of the Preliminary Year

The U.L.U. medical group is also preparing a reply to Lord Annan's letter to Guy's and St. Bartholomew's in which he suggests that their preliminary year course (the old 1st M.B./B.D.S.) be phased out in the interests of economy. The future of this course has been the subject of much emotive debate at Guy's over the past ten years. This whole question is far too involved and contentious to discuss fully here, but as you may imagine, your student representatives on the Clubs' Union and S.M.E.C. are opposing this plan as vigorously as they are able, both at Guy's and through the machinery of the Students' Representative Council of the University of London Union.

The Club's Union Officers were empowered to do this on your behalf, for at the last general meeting of the Club's Union a motion was carried which instructed *"All student representatives to ensure, as far as they are able, the continuation of this worthwhile course producing many fine doctors and dentists".*

Summer General Meeting

This illustration of the important policy-making prerogative of General Meetings makes a convenient introduction to remind you all that the Summer General Meeting will be held near the end of this term, probably in the week beginning the 18th June. This then is an occasion at which you can change the direction of emphasis of your Union Council and at the very least come and participate in the debate on the constitutional changes that were proposed by last year's executive.

The Summer Festival

The Summer Festival will be held on June 2nd. By the time this appears in print I expect the entries for the 5-a-side football will be closed. But there may well be room for more contestants for the games. These include events ranging from egg catching and barrel-rolling to rugby ball dribbling and volleyball, the general idea being that little athletic ability and no stamina is required to fully participate and entertain the spectators.

Chas Newstead.

Fear of Flying

by Maurice Yaffé, Senior Clinical Psychologist, Guy's Hospital

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Over the past few years flying has become one of the most convenient and comfortable ways to travel, and the introduction of low fares, especially across the Atlantic, has made it accessible to many more people. Air travel is extremely safe; according to Lloyds insurers it is twenty-five times safer to fly than to drive a car. However, statistics from the U.S. indicate that a considerable proportion of those passengers who do travel by air are anxious about it; these are in addition to the truly phobic who actively avoid flying at all costs. Estimates from the United States suggest there is probably an anxious flyer in every American family, and it is fair to assume that there are a lot of people in the U.K. who feel the same way. Aircrew themselves are by no means immune to anxiety in relation to flying and a small number of cases have been reported in the clinical literature.

What can be done for the fearful flyer?

About four years ago Pan Am in Chicago initiated a two-week seminar programme specifically designed to help the anxious flyer, since which time over 1,000 people have passed through it. Their average person is 39, and has had 3.8 years of college, and there are twice as many women as men. Treatment comprises relaxation exercises, an imaginary flight session (presented verbally by the therapist), a session in an aircraft hangar and walking around inside a plane. This is followed by a look at the control tower, after which the class get on

a plane and taxi down the runway. On the seventh session the class take a "graduation" flight and Pan Am claim that out of an average class of 55, there are usually two or three dropouts. The course costs U.S. $100.

The British Approach

British Airways in acknowledging the problem recently made a film, to be entitled *First Flighters*, of a trip they organised to Rome for fourteen people around Great Britain (aged 22-79) who had never flown but were anxious about it. I was fortunate in being allowed access to these people and was able to collect some valuable data. They first of all took part in a question-and-answer session with B.A. personnel including, amongst others, a flight captain and air safety officer. The issues they were most concerned about were:

What happens if one of the engines stops?

How does a great heavy thing like that stay up?

How fast and how high are we going?

Will I be air sick?

Are we closed in?

Can we walk about on the aeroplane?

Do we need some foreign money for anything on board?

The most frequent specific fears reported in relation to flying were concerned with: take off, landing, crashing, mechanical failure, storms and turbulence, drop in altitude, illness during flight, and hi-jacking.

None said they had sought help previously to overcome these fears.

The most common symptoms of their fears were: stomach upset and tightness, sweating, feeling faint, shaking, facial flushing, and gritting teeth.

The favourite methods used to relax whenever tense included: an alcoholic drink, smoking, listening to music, reading, watching television, lying down, knitting, and taking a car ride (preferably before flying!).

Most felt somewhat re-assured by the factual information given by the panel, but two said they were rarely impressed by statistics—they would "wait and see". After the panel discussion they were taken to the airport to look around a hangar and inside a Boeing 747, the kind of plane in which they would be going to Rome the next day. I was able to take subjective ratings of anxiety that day, on the morning of, and immediately prior to, the flight, as well as before the return journey the following morning. Relaxation exercise sheets were handed out the day before the first flight. Ratings consistently showed a move towards increased relaxation after the outward flight, and there was a significant reduction in fear ratings between those made immediately before the flight out and the return flight from Leonardo da Vinci airport, Rome.

Conclusion

From this exercise it seems that anxious individuals who have never flown can do so and enjoy the experience. For those whose flying fears are more severe—the truly aero*phobic*—behaviour therapy techniques have been shown to be extremely effective; they include: *systematic desensitisation* (this involves systematic presentation in imagination of specific components for the fear related to flying, from least to most feared, along with instructions to relax), and *habituation* (repeatedly showing in a simulated flight set-up anxiety-provoking aspects of flying in order to extinguish the fear response). Cassette tapes of relaxation exercises and flight stress control are available commercially.

The author peers out at the Medical School from the unique Guy's Hospital aircraft cabin mock-up used in the treatment of phobic patients.

Until recently, airlines have been slow to admit that there are people who are afraid to fly, whether they have flown before or not. Now that a reliable treatment method is available we look forward to continued co-operation with British Airways and other airlines. The case of the American lady who spent three days at Heathrow last summer petrified of boarding the plane will soon become a story of the past.

Paul Fisher and Mary Ganczakowski add:

Recently we accompanied two phobic patients who were taken on their "graduation" flights on the British Airways shuttle service from Heathrow to Edinburgh. This is an ideal type of flight to use as the efficiency of the system means that long delays are avoided and the whole procedure can be carried out within a day, whilst still allowing plenty of time at the destination.

A view of the cabin simulator used at Guy's Hospital.

From the start, British Airways were most helpful and the understanding of the cabin crew made our task much easier. Those of you who have flown on Trident 3 aircraft will appreciate the marked lack of noise (from the inside anyhow) and with calm conditions for take off, the climb out from Heathrow was very smooth. One patient could hardly be restrained from undoing her seat belt to get a better look out of the window, such was her disbelief, and I think enjoyment, of the whole procedure.

As a special dispensation, the crew invited us onto the flight deck which was especially useful for the patients who could then see and appreciate what was going on. It must have appeared that all the crew have to do is sit there and watch a few dials as for most of the time the aircraft is flown by autopilot. Apart from slight turbulence on the approach into Edinburgh the remainder of the flight and landing were uneventful and both patients left the aircraft unscathed.

On the return flight, the cabin and flight crews were once again most understanding and helpful. With the weather improving the view from the flight deck was quite outstanding and a tailwind meant that we were back at Heathrow in less than 50 minutes.

Both patients found the whole experience very rewarding and effective, as, following a life time of avoidance, one is quite happy to book her flight to Spain and the other his trip to America. In the light of this experience the future of this project looks very promising.

We would like to thank British Airways for their invaluable help in this new venture.

The Keats House Carvings

"If stones could speak what tales they would tell"

by **T. H. E. Orde and Adrian Pini.**

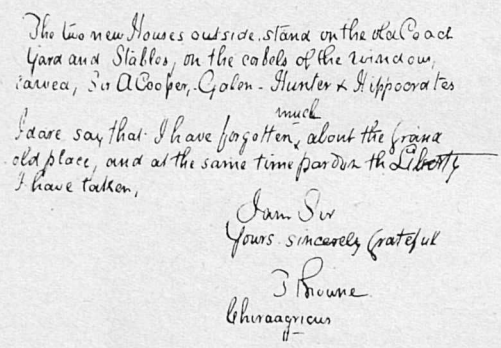
It is not for want of trying that the identities of the four faces carved on the facade of Keats House have remained an enigma. In 1965, after cleaning of the brick and stonework of the building, the late Sir John Conybeare invited readers of the *Gazette* to help unravel the mystery. The theme was taken up by the *South London Press,* who quoted Sir John to the following effect:

"One with a beard suggests Shakespeare and another, a classical figure, resembles Homer. The other two could be Victorians, possibly poets of the era".

The suspicion arises that Sir John believed nothing of the sort but had impishly offered this unlikely literary quartet as a sort of Aunt Sally. In the event nothing ensued from this initiative and researches in the hospital records and beyond carried out at the time proved unfruitful.

However serendipity is sometimes more rewarding than design in resolving obscurities of this sort and three years later a letter, dated 19th December 1903, came to light during an entirely different investigation. This letter, addressed to Mr. Cuthbert Golding-Bird (Surgeon at Guy's 1975-1906) and reproduced in facsimile in the *Gazette* contained the reminiscences of a certain T. Browne who stated that he had once been a Guy's patient. About Browne, or the authenticity of his letter, nothing is known, but there seems little immediate reason to doubt the accuracy of his descriptions of the Hospital and its environs.

The letter ends:


The two new Houses outside stand on the old Coach Yard and Stables, on the corbels of the window, carved, Sir A Cooper, Galen - Hunter & Hippocrates

I dare say that I have forgotten much about the Grand old place, and at the same time pardon the Liberty I have taken,

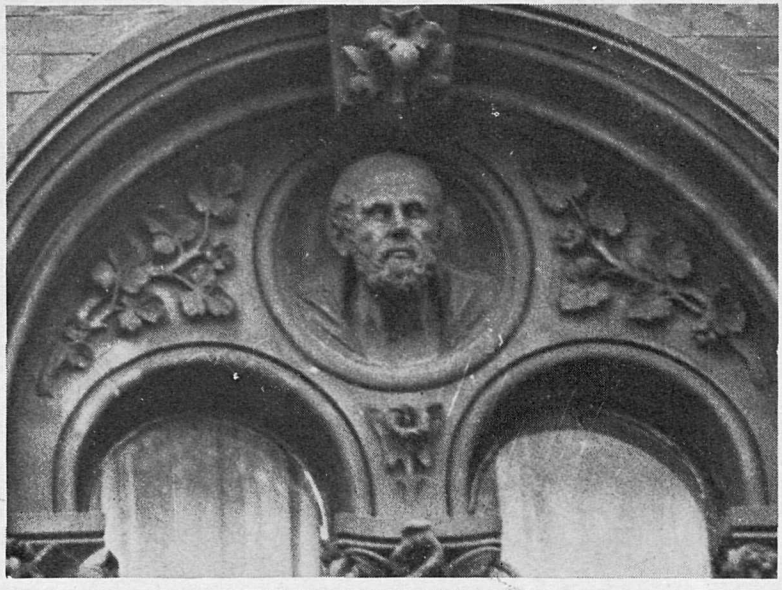
Iam Sir
Yours sincerely Grateful
T Browne
Chiraagricus

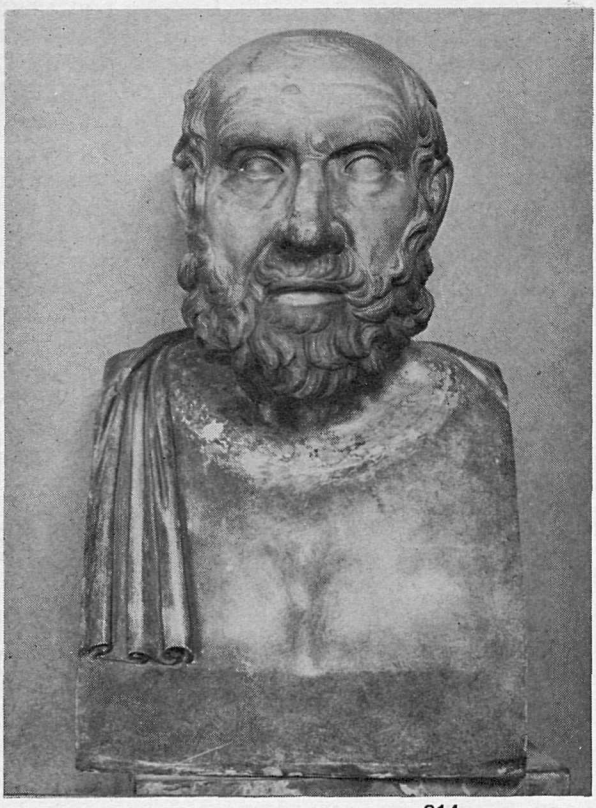
"The two new houses outside stand on the old coach yard and stables, on the corbels of the window carved, Sir A. Cooper, Galen, Hunter and Hippocrates".

T. Browne signs himself *Chiraagricus* and while this may be a surgical malapropism it might be a reference to his poor handwriting via the more closely related *Chiragricus,* meaning gout of the hands.

Clearly Sir John and T. Browne had different ideas, but as is evident to the eye and implicit in Sir John's selection only one of the four is obviously associated with the classical past. Furthermore Browne finds

no place for the lightly bearded figure (evidently Sir John's Shakespeare) whose attire would pin him down to the Elizabethan/Jacobean period (see page 217).





Above:
The heavily bearded figure at Keats House. Is this Hippocrates?

Left:
Bust of Hippocrates in the Uffizi Gallery in Florence.

Keats House was completed in 1863 as a result of the Governors' intention to provide residence for two of their medical staff, the first occupants being Dr. Braxton Hicks and Mr. Cooper Forster. As recorded in the *Builder* of September 12th, 1863.

"The principal materials used are red brick with Bath stone dressings. The columns of the portico are of polished granite. The cost, including fittings, stoves, etc., has been for the two houses £5,620 . . . The carving is by Mr. Seale (J. W. Seale) *of Walworth".*

Astley Cooper died in 1841 and there would have been numerous persons at Guy's in the early 1860's who remembered him well and who might have wished to commemorate him through Mr. Seale's carving for the new buildings.

J. W. Seale was later commissioned to sculpt for the Guildhall Library and amongst his many works is the head of William Harvey, representing Medicine. J. W. Seale, therefore, was no stranger to sculpting from archetypes. One of Seale's contemporaries was Joseph Towne, the gifted creator of the wax anatomical models in the Gordon Museum. Towne was also a sculptor of some standing and amongst examples of his works which may be seen in the Medical School is a marble bust of Sir Astley Cooper. This was probably completed shortly after Sir Astley's death and was acclaimed to be an excellent likeness of the famous surgeon, so much so that it is reported to have guided the sculptor of Sir Astley's monument in St. Paul's Cathedral. That J. W. Seale used the Towne sculpture while working on Keats House is certainly a possibility. The bust of Sir Astley Cooper in the Medical School bears considerable resemblance to one of the Keats House effigies and may well be modelled on Towne's work.

Sir Astley Cooper at Keats House.

To add to the difficulty of establishing epochs for the effigies Sir Astley is portrayed by Towne in a classical toga, but one very similar to that of the carving of Sir Astley Cooper imputed to be of him at Keats House.

Sir Astley Cooper
by Joseph Towne.
(Bust in the Medical School)

Although little is known of Seale much more is known of his son Barney. Amongst Barney Seale's best known works is a bronze head of the artist Augustus John, and *Boswell's first meeting with Dr. Johnson,* first exhibited at the Royal Society of Arts and now in the Queen's private collection. Of Barney Seale, Kineton Parkes notes in the *Appollo* magazine of 1931 that:

". . . He began life as a carver. His father and grandfather were carvers; he began to carve in situ *on London buildings in 1911 . . . he is now carving on the Houses of Parliament. But he produces no carved ideal sculpture, only modelled."*

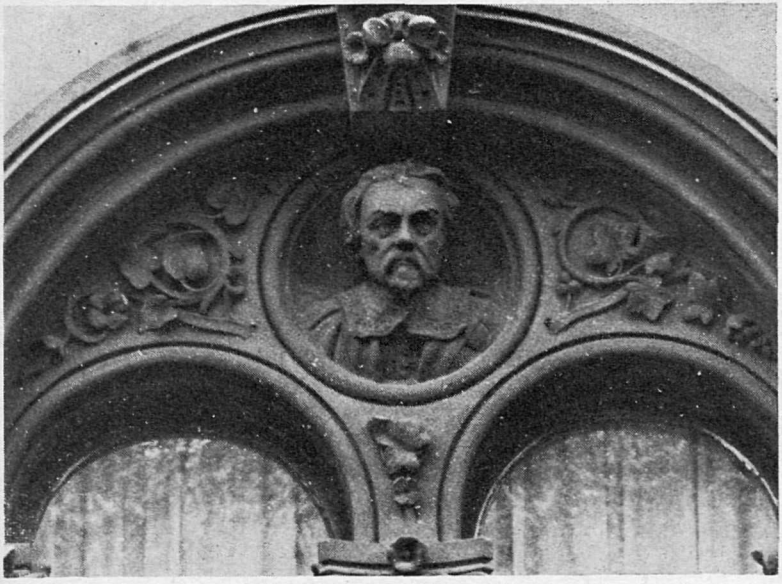
It is quite probable that he was influenced in this technique by his father and it is therefore very reasonable to expect carving modelled on the archetypal figures of Medicine.

As for the remaining trio, evidence is lacking and to a greater or lesser extent wishing must father the thinking. Certainly if William Harvey (1578-1657), who published his treatise, *De Motu Cordis* in 1628, springs to mind as a strong claimant, as does John Hunter; however, if pre-eminence is looked for then the "father of modern medicine", Hippocrates, must surely qualify.

We thus find ourselves hardening in the view that the faces shown in the figures represent or were intended to represent, Hippocrates, William Harvey and Sir Astley Paston Cooper. Hippocrates bears a very general likeness to the sculpture in the Ufizzi Gallery in Florence while that of Harvey rests perhaps more firmly on the basis of his pre-eminence in medicine at the period indicated by his dress. If anyone has doubts as to the accuracy of the Astley Cooper identification let him spend a few moments making a comparison with the Towne sculpture in the Medical School.

A portrait of William Harvey.

Is there a resemblance to one of the Keats House figures below?



By including Harvey we are partly rejecting Chiraagricus' recollections of 1903, a circumstance which tends to lessen the reliance of his testimony in furnishing a name for our fourth figure. He has given us Galen and Hunter to consider. The former it seems must be ruled out on grounds of dress alone, and we cannot disguise the fact that the features of the carving below refuse to conform with those of well-known representations of the more famous of the Hunter brothers. This consideration however loses some of its force if the name of Jenner is substituted for Hunter.

William Jenner—an impish suggestion?

William Jenner, with his somewhat heavy features is accordingly put forward as the more likely subject of our last illustration, albeit in the spirit of the late Sir John Conybeare, to challenge readers of the *Gazette* to provide more convincing alternatives.

Towards Healing

Julia Fabricius, Nursing Correspondent

A conference to consider the wider aspects of healing and health was organised by the Hospital Chaplain, The Reverend Robert Kempster, and held on February 13th. It was chaired by Mrs. M. Davis, the District Nursing Officer, and attended by about sixty staff of various disciplines and some local clergy.

There were three speakers; the Chaplain spoke on the topic "If you've got health you've got everything"; Miss Brysson Whyte, the Director of Nurse Education on "Angels?" and The Reverend Michael Whinney, Archdeacon of Southwark on "What I want is a miracle".

Robert Kempster started his talk by telling us that in a survey of a number of men published in *Playboy,* health was rated first in the list of requirements for a good life. He then discussed the need for a balance between physical and spiritual health, but said that increasingly people thought that physical health was more important. In hospitals cure came before care; the body often seemed to be thought of as a machine with parts which could be replaced rather than something containing a human being. The Christian religion taught that physical and spiritual health were important; there were many people to whom Christ did not give physical healing and He showed that complete healing must include our death. Physical health does not always bring happiness and true healing can come through suffering. To illustrate these statements Robert Kempster mentioned the state of the British nation in the war compared with the present time, and the pain of mourning which was necessary for the resolution of grief. To help our patients towards healing we need contributions from many different specialists—physicians, psychiatrists, priests, and we need to be able to accept inevitable physical illness. If we could do these things there would be many benefits, not least a greater understanding of and respect for human beings.

Brysson Whyte, as the middle speaker, referred to herself as the *"profane contribution to a sacred sandwich"* and said that she was not used to the pulpit. However, her contribution proved to be stimulating and far from profane. She said that nurses were in fact not "Angels" as the general public thought, but could better be compared to "Daleks". For those who did not watch *Dr. Who* she explained that daleks were rigid, shiny automatons who gave a stereotyped response to questions for *"exterminate"* hear *"no more analgesia for four hours"*). Inside a dalek was a vestigial human creature. Miss Whyte said that nurses were not born daleks but the hospital environment gradually had this effect on them—*"the milk of human kindness becomes hard cheese"*. From the word go nurses have to cope with the distress of patients and relatives often without adequate support. There are five ways in which nurses build up this dalek like exterior: (1) "re-assuring the patient" instead of encouraging the expression of his fears. The flames of his anxiety are damped down with a blanket so that they consume him only; (2) "cleaning cupboards"—keeps one away from awkward questions; (3) maintaining a rigid hierarchical structure; (4) making the patient fit into a routine instead of attending to his individual needs; (5) dividing the patient into three parts—the physical part can be cared for without causing pain to oneself, the social and spiritual parts can be left to the care of social workers and chaplains. How then to "heal the healers"? Brysson Whyte said that nursing is really loving the patient and that nurses do have the ability to care for the complete person. In order to love and understand our patients we need to show more love and understanding to each other—and that is how to turn daleks into humans.

Michael Whinney agreed that the physical and spiritual dimensions of health needed to be balanced. He attached much importance

to Divine influence on physical healing as well as spiritual. He recounted a number of instances, including one about an illness of his own, when the power of prayer had seemed to have an important part in the healing process. He said that it was not important to say whether these happenings had been miracles—or indeed to try and find reasons for many of the joyous or sad things that happen. As a Christian he believed that Christ's purpose was "wholeness" for everyone. He never refused healing although it was not always given in the way in which it was expected. Michael Whinney said that he was not in any way underestimating the value of medical skill, "the God given knowledge" of the medical profession should be used for God's healing purpose.

There were two main topics in the informal discussion period in the afternoon. The first was how to have a greater involvement of and communication with the different people who can help the healing process. The comment was made that getting doctors to acknowledge the need for contribution from other professions and to be involved in discussions with them was one of the greatest difficulties in this area. Some time was then spent talking about the problems of staff caring for dying patients, i.e. those who are not going to achieve physical health.

In summing up, Mrs. Davis said that everyone would be stimulated to think more deeply about all these issues. She was sure that there would be an effect on the care given to patients in Guy's even if this was not apparent immediately. Certainly it was an interesting and thought provoking day, and thanks are due to the chairman, the speakers, and to the Chaplain for planning the event.

Habeas Corpus – Synopsis and Review

by Sarah Pearson and John Duckworth

Bosoms, bottoms and doctors are a winning combination for any Guy's audience (well-known for its low-brow preferences), and *Habeas Corpus* by Alan Bennett is full of them. With this well-chosen play the Theatre Club produced a vivacious and stylish performance (Ballroom, May 3rd/4th) directed by Tim Lancaster.

The story of a G.P.'s family in Hove, and their love-life, is strung together by the cleaning-lady, Mrs. Swabb. Kate Lockwood played this with imagination and confidence. First to be introduced is Arthur Wicksteed, well-played by Andy Emerson, but what a pity his make-up made him look like a panda! As a conscientious G.P. his sexuality has been smothered by his professional manner: *Doctors can touch anybody because they don't have the feelings to go with it. That is what they go to medical school for.* Sarah MacDonald played the histrionic wife Muriel splendidly, particularly when she later throws her inhibitions and her pale orange cardigan (all wore brilliant costumes, put together by Diedre Walpole) to the winds. Their adolescent son Dennis (Peter Robinson) is despised by both as a "lounge lizard", and comforts himself with hypochondriacal musing most convincingly. The doctor's sister Constance (Sarah Evans) is also resident; at 33 years this unmarried flower has one desire: to possess an enormous pair of tits. Unfortunately Sarah is far from flat-chested, but played the part so

demurely it did not matter. Constance is openly admired by Canon Throbbing, a fresh young vicar (well-cast Keith Lloyd) who seeks her hand in the naive hope that marriage will stop him from looking up girls legs. She is not so keen, and procures for herself a pair of prostheses in the hope of catching a more dashing male.

The family dynamics are soon upset by the arrival in Hove of Sir "Percy Blinker", K.C.B., F.R.C.S., F.R.C.P., President of the B.M.A., well caricatured by Wilfred Treasure. He has always fancied Muriel, and is bent on Dr. W.'s revenge. The good lady is only too ripe for a bit of a fling and arranges an afternoon alone. . . . Also new in town are Lady Rumpers (Imogen Tucker) and her shapely daughter Felicity (Sarah MacGreery) whose lovely body soon captivates both Dr. W. and his unattractive son, not to mention the audience.

As Muriel awaits Sir Percy's arrival the delightful Mr. Shanks (very well played by Peter Jolliffe) appears as the sales rep. to advise Miss W. on her new bust-line. This is where the first boob is made (sorry) as he mistakes Mrs. W.'s real ones for falsies and from then on things get confused by much groping of breasts and a whole series of men without their trousers.

The plot begins to smooth out when it is discovered that Felicity was the product of a night of passion between Sir Percy and his patient, Lady Rumpers, a fact which he would rather not have disclosed to the B.M.A., although *"The doctor-patient relationship is itself a kind of seduction"*. The story ends with couples pairing in quite a romantic way, and Dr. W. sums things up with the testing line: *"He whose lust lasts, lasts longest"*.

The set was very simple: just two chairs, and the confidence of the acting and well-thought out costume combined to give a very slick performance, obviously enjoyed by both audience and cast. It's good to see talent back in the Theatre Club.

Sarah Pearson.

J.R.A.D. writes :

Many of the recent Theatre Club productions have quite rightly been subjected to a lot of criticism. The tradition of three major productions a year has fallen by the wayside and there have been some notable, and financially ruinous, fiascos. The Greenwood Theatre, which should be a godsend to any student drama group worthy of its name, seems to have created more problems than it has solved over the last two years. It was thus with considerable trepidation that I went to see the most recent production, *Habeas Corpus,* in the Ballroom.

Tim Lancaster gave himself a head start by choosing a modern farce centering around big breasts and doctors with which it would have been difficult to displease a Guy's audience however bad the production had been. No criticism intended here; plays need audiences, a commodity that can be all too thin on the ground at Guy's, and this play deserved a large audience.

On balance, I think this was the finest production I have ever seen the Theatre Club do. The standard of acting reveals an obvious wealth of talent; how relieving to see a cast of twelve which doesn't have at least one "actor" in it who crosses the audience's embarrassment

threshold with his every appearance and utterance; and how satisfying to see the polished and controlled performance that Andy Emerson gave as Dr. Wicksteed. Peter Jolliffe (Shanks) is a very talented character actor and I hope we will see more of him in future productions.

Above all, this must be a triumph for Tim Lancaster who directed a large cast on a minute stage area with virtually no props and yet at all times was able to maintain the requisite "suspension of disbelief". I hope that this is going to be the first of many strong productions and that above all the Greenwood is going to be used to its best advantage. There can be no excuse for people of this talent not succeeding in the fully equipped theatre that sits on their doorstep.

Music Club News

by Mark Cronshaw

The last in a series of seven lunchtime recitals in the chapel will be held on Friday June 8th at 1.20 p.m. Malcolm Ross (violin) will play Bach's *Partita in B minor.* As from Monday, May 14th madrigal group singing has been held in the ballroom of Boland House. Anyone interested in joining in is most welcome—just come along any Monday evening at 5.30 p.m.

Following the success of the present series of recitals (see review below) another series is to be held in the autumn. It is intended that in this second series some of our musical talent will take part. Anyone interested in doing so please contact me or Wilf Treasure through the music club pigeon hole in Boland House. Music tuition should be available soon to anyone interested. This could provide an ideal opportunity for the many potentially good instrumentalists in Guy's to get into practice again, and perhaps form a permanent orchestra. More details will be announced later.

Review

The first in a series of summer lunchtime recitals was held in front of an audience of about 35, on Friday, April 27th. The programme consisted of piano music by Bach, Schumann and Lutoslawski played by Iain Burnside. The Bach was the *Prelude and Fugue in A Flat* (Book 2 of the 48). It was given a refreshingly cool and flowing account, the elegant surroundings of the chapel providing an ideal setting. Schumann's *Fantasie in C major, Op. 17* followed.

The final items were two studies by Lutoslawski, which formed a most dramatic and surely technically dramatic ending to a magnificent concert. Iain Burnside is currently studying at the Royal Academy of Music. He demonstrated an enviable fluency and obvious understanding of this rather varied programme.

The following Friday, May 4th, saw a concert of woodwind ensemble and solo 'cello. The artists were again students at the Royal Academy: Douglas Boyd (oboe), Mark Pledger (oboe) and Sarah-Jane Measures (cor-anglais)—the **Trio Cannello,** with James Potter ('cello).

The woodwind trio gave a fine display of composite playing in an arrangement of Beethoven's *Trio, Op. 87* in front of an audience of thirty or so. The combination of very sensitive dynamics and a sustained and sweet singing tone made a delightful sound.

James Potter ('cello) gave a very satisfactory performance of excerpts from Bach's 3rd *'Cello Suite in C.* The expansive and vigorous opening movement, *Courante,* led into a very well held and confident *Allemande,* finishing with the *Bourreé nos* 1 and 2. The concert concluded with a modern piece, Alan Richardson's suite for two oboes and cor-anglais.

Of course the soloists in both these recitals made one or two slight slips, but it would be churlish to criticise them for this, the overall effect being excellent. It is to be hoped that the rest of this series of recitals will be of the same very high standard.

Quodlibet Society

RICHARD GORDON

May 10th, 1979

How to be a doctor without actually practising Medicine —and vice versa

Richard Gordon's fame stems from his creation of the archetype consultant in Sir Lancelot Spratt, and for painting a colourful image of medical students of which so many patients are aware (or terrified)!

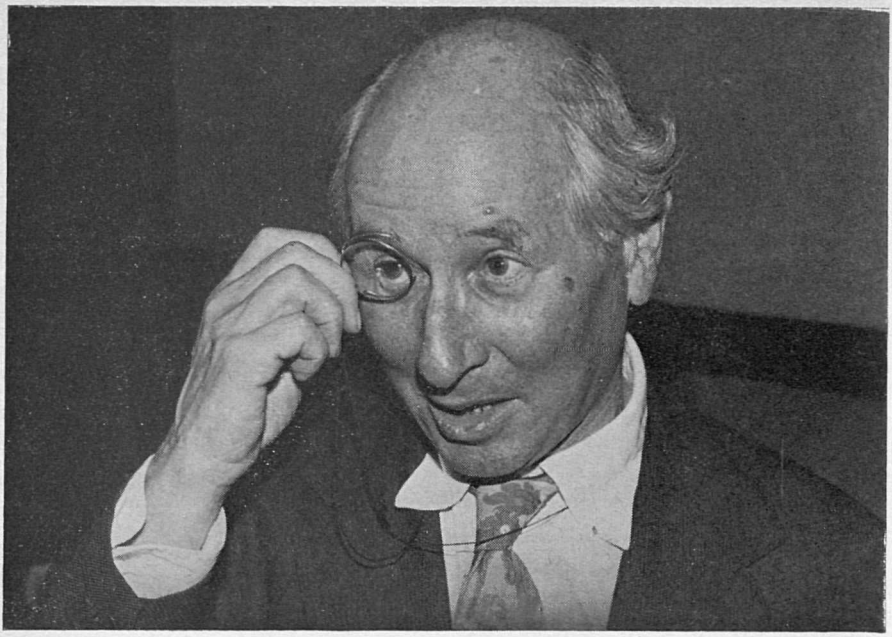
After only five years in practice he had recognised that unlike medicine, writing came naturally to him. Having carefully considered the implications of leaving medicine, to want to speak to the Professor of Anaesthetics at Oxford:

"Well Doctor, I usually try to discourage any man from leaving the profession; but after having you work for me this last eight months, I am convinced you have made the right decision."

Dr. Gordon readily admits that his "Doctor's series" provides apt reading for the hospital bedridden; he was recollecting the lady who, addressing him with a smile, said: "I am so sorry my husband died when only halfway through your last book".

The effort of writing this series of medical mishaps becomes greater with each new addition—he longs to leave that behind, but happily reflects on the fame it has brought him.

One is quickly aware of Richard Gordon's abrupt yet humorous manner, reminiscent of the Thurburean leftist intellectual—not so much listening as waiting for an opening. Expectantly, I asked him if he managed to travel very often, "Oh yes", he replied, "I was in Watford last weekend!"



Richard Gordon at the Quodlibet Society. V. Mak

The list of medical novelists and poets is indeed impressive—Quodlibet afficianados will be well aware of the remarkable literary contributions John Keats made during his tragically short life. Richard Gordon reminded us of a few others: Somerset Maughan, Sir Arthur Conan Doyle, Edward Jenner and Chekhov. Medicine has also lent itself to the subject matter of many literary works, including George Bernard Shaw's *The Doctor's Dilemma* and George Elliot's *Middlemarch.* This masterpiece written in 1871–72 reminds one of the relatively recent application of technology to medicine. Dr. Lydgate was considered far ahead of his time in both medical theory and practice since he possessed —and indeed used—a stethoscope.

Dr. Gordon was at pains to point out that his writing ability was not confined to the antics of the housemen and Sir Lancelot. As a medical historian he expresses delight in his work on Florence Nightingale—and boyish pleasure in suggesting that she was a lesbian (much to the distaste of our neighbours). He has most recently turned his hand to exposing the real Jack the Ripper or was it Rippers—Dr. Gordon isn't sure.

So does he recommend that more of the medical profession turn to writing? . . .

"Not at all", he growled, noticeably adjusting his well-handled monacle, "books are things to beg, borrow or even steal but never to be bought", and if medical books—not to be read, said a voice behind me.

Richard Trembath.

Next meeting 11th June: Eric Heffer, M.P.
(Prominent Labour M.P. back bencher)

Nursing

Forty Years On

Once a year, on a Wednesday early in May, a large number of Old Guy's Nurses arrive at the *alma mater* for the Annual General Meeting and get together of the Guy's Hospital Nurses' League. For many of them it is obviously an important occasion. Some travel considerable distances and most wear their best clothes. Some of the Old Guy's Nurses really are old, and it must have been difficult and tiring for them to attend, but all look pleased and proud to be there.

As they walk around the hospital, they express wonder at how things have changed. The buildings and the uniforms they can see, and with these things most feel that nurses and nursing must be different too.

How far have we departed from the ideals of service and excellence that makes these people proud to be Guy's nurses? Some people would also ask how much the Old Guy's Nurses' memories of the excellence has faded with the years.

I feel from talking to many "O.G.N.'s" that there can be no question that the nursing was excellent. For instance, they practised nurse-patient allocation and total patient care in a way that many people now are just beginning to discuss, although with longer working hours and a slower turnover of patients than we have now. On the other hand, a number of "O.G.N.'s" have told me that they spent much of their training in fear of "what Sister would say" and kept out of the way whenever possible. We still have the legacy of this "nurses should be seen and not heard" attitude which is hard to lose, but nowadays most student nurses are not frightened to ask questions and to make suggestions about the care of their patients.

Of course, it is the social and medical changes of the last fifty years that have caused nursing to change. However, I believe that nurses are much the same. Nearly all have a strong desire to give excellent nursing care—in fact what can only be called a vocation. Some of the changes have caused difficulties in nursing that can lead to frustration and disillusionment, but some have made opportunities for many people to contribute to good patient care. The sense of fulfilment when one's patients have been well looked after is something that cannot have changed.

When this generation of Guy's nurses become "O.G.N.'s" will they be as proud of their training school? I am sure Guy's will always retain the loyalty and affection of people who have belonged here, but nurses also feel a sense of loyalty to the nursing profession as a whole. Increasingly this is becoming more organised and is trying to set high standards which apply to all nurses. A considerable proportion of the trained nurses in any hospital nowadays will have come from another training school, and this leads to the appreciation and introduction of new ideas and methods. These things are bound to lead to a lessening of the ties with any single institution, without which we would not continue to make the progress in nursing which is needed to keep pace with the social or medical changes. So, perhaps in the future we will feel a different sort of loyalty to Guy's, but the pursuit of excellence in nursing, for which Guy's has always stood, will continue unabated.

Julia Fabricus.

Physiotherapy

The *Council For Professions Supplementary to Medicine* has a multidisciplinary working-party beavering away on the educational policy that it feels would be appropriate for the several professions which gather beneath its mantle. This group has, as active participants, representatives from the Education and the Health Departments, and has within the last few months produced a document laying out the alternative responses which the Departments might be willing to make to the pressure from the professions for academic recognition. As the reader may know, some of the "supplementary" professions are already well on the road towards all-degree status, while others, like physiotherapists, have yet to produce their first home-grown graduate.

Into the ring, the D.H.S.S. has now thrown its own two-penn'orth in the form of a draft paper on graduates in the remedial professions. This aims, it says, to establish a consensus between the various factions on the way in which a big enough sample could be produced at the lowest charge, in order to allow valid conclusions to be drawn as to the cost-effectiveness or, indeed, the very desirability of having degree-courses in the therapies.

Both of these papers have generated considerable heat. They have been seen, perhaps unreasonably, as attempts to stifle an ambition to give our training more of an educational bias, and to achieve the academic status which we feel we deserve. We are, in Britain, rapidly becoming the educationally-deprived of the therapeutic world. We are also, within our own country, seeing ourselves given a lower academic rating than, for example, speech-therapists, dietitions and social workers. We have situations where higher educational requirements are made of entrants to our diploma courses than are made of entrants to degree courses in the same educational institutions.

Small wonder that there is dissatisfaction at what we see as the grudging D.H.S.S. proposition that ten per cent of therapists should be graduates. But is that what is meant? The phraseology is inexact—is it ten per cent of the intake, or ten per cent of the output per year, or ten per cent of the whole therapy population that is intended? If the latter, we will have to wait for the turn of the century before the modest one or two degree courses postulated will have that effect.

Then there is the question of the form these courses should take . . . should they be, as in Ulster, four-year courses with a specific professional commitment? Should they be remedial professions joint courses with a split into a particular branch at some later date? Should they be "top-up" or "end-on" courses at the conclusion of the diploma course? Should we restrict entry to training to first degree-holders rather than "A" level entrants and mop up the un-placed graduates of other disciplines by giving them a shortened orientation course? Should we press for acceptance of our diploma as equivalent to a first degree for entry to M.Sc. courses? Or is the academic and practical content of our present course equivalent to other vocational degree-courses like engineering, anyway? Would a three-year degree course in physiotherapy plus a one-year pre-registration internship do?

We've got problems. . . . But that the D.H.S.S. has accepted a ten per cent graduate profession is a major breakthrough and we welcome the implicit recognition that the need, and the potential are there.

Ronald Cooper.

Book Reviews

"The Language of Pathology", by Glyn Walters. Pp. 208. Price £4.75. Published by H. M. and M. Publishers.

This is an unpretentious, balanced review of the major diseases in medicine at a simple level, concentrating on an explanation of anatomical, pathological and medical terminology. I feel that some of the diagrams could have been improved. There were unfortunately a number of inaccuracies and some of the information was out of date which inevitably detracts from the book as a whole. I feel, therefore, that this is quite unsuitable for serious students of medicine, although it could be of some assistance to persons in the paramedical disciplines.

D. R. TURNER,
Reader, Dept. Pathology.

"Sexually Transmitted Diseases", by C. B. S. Schofield. Pp. 250. Price £3.25. Published by Churchill Livingstone Medical Text, 1979.

Dr. Schofield is an experienced writer, clinician and researcher in the field of genito-urinary infection, and is able to see his subject in its aspects of clinical medicine, epidemiology and infection, and the symptomatic presentation of an emotional and social difficulty in the patient's situation.

'Sexuality Transmitted Diseases' is a clearly written short textbook that attempts to present the subject in a clinical context, without overlooking the nature of the infections, their transmission, microbiology and immunology.

To see certain urogenital conditions out of a clinical context, and to fix a behavioural label on them is so much the general tendency on the part of some professional people and of the public that these conditions are often seen in unrealistic perspective, and in consequence are inaccurately diagnosed. This volume goes some way towards achieving a balanced view.

For the present purposes, the description of early infectious syphilis is precise and clear. The system disease of late visceral syphilis is likewise quite adequately covered, and at a time when fewer clinicians are seeing anything of the clinical disease; and a good knowledge of it is now becoming unusual.

A number of genital and pelvic conditions are described which are relevant to the diagnosis and the treatment of inflammatory disorders in the pelvic and pudendal areas, within the context of infection and its relatedness to sexual activity. This is a book to be recommended.

A. S. GRIMBLE,
Consultant,
Dept. Genito-Urinary Medicine.

"Aspiration Cytology of the Breast", by Dr. Hubert Schöndorf. Pp. 141 + ix. Price £27.50. Published by W. B. Saunders, 1978.

While diagnostic exfoliative cytology is a method of proven value for the recognition of both infiltrating carcinoma and precarcinomatous epithelial changes at a number of sites, the cytological study of cells aspirated by syringe from solid and cystic lesions of the breast is still at the stage of critical evaluation. This monograph from Frankfurt gives a clear picture of the present situation.

The technique emerges as a most valuable one in skilled hands, but one that is inherently unlikely ever to achieve quite as high a degree of precision as histological examination in the diagnosis of malignancy in the breast. Tumour cells may be difficult to obtain from small-celled scirrhous carcinomata. Because the malignant cells are seen out of their normal context with the tissues, the method does not discriminate between intraduct (*in-situ*) and infiltrating neoplasm. Furthermore, because some cells are of equivocal significance, a small proportion of smears—as with cytology of other sites—are inevitably scored as "suspicious", while all the published series quoted include examples of false positives and false negatives (in the author's series both these categories account for 3 per cent of the specimens). He recommends that an unequivocal cytological diagnosis of malignancy should be confirmed histologically with a biopsy.

The author uses two staining techniques—a Romanowsky method (May-Grünwald-Giemsa) applied to air-dried films and the Papanicolaou technique on fixed smears. Most of the colour plates are photomicrographs of films prepared

by the former technique: the minority, stained by Papanicolaou's method, show greatly superior nuclear detail.

A little of the pathological terminology used is unfamiliar to the British reader. The principal example, which forms part of Fig. 92—a table reproduced from a publication by other authors—is the puzzling comment on the management of patients with multinodular breast lesions: "Mastectomy advisable if proliferative mastopathy is suspected".

There are 123 references and a serviceable index. This book provides a critical and balanced survey of the present place of aspiration cytology in breast disease.

G. A. K. MISSEN,
Consultant, Dept. Clinical Microscopy.

"Pathobiology: How disease happens", by Frances K. Widmann. Pp. 401. Price £8.15. Published by Little, Brown and Co.

This book is disappointing because apart from superficial coverage of a range of general pathological topics it does not tell the reader how disease happens. Indeed a number of recent advances in our understanding of disease processes have been omitted.

The first 42 pages deal with a very elementary account of normal histology. The remainder of the book is general pathology with a few items of physiology and general medicine interposed. I found a number of errors and misleading generalisations, i.e. "antibodies are such large proteins they generally remain within the blood stream", page 102 (which is only true for IgM); "Coronary arteriosclerosis is an independent cause of myocardial hypertrophy", page 158; "No human cancer has been proved to result from a specific viral infection". (Burkitt's lymphoma is certainly generally accepted as being related to the E.B. virus provided previous stimulation with chronic malaria has occurred) and several more. I did not think the definitions of the major pathological processes were as clear as they might have been. The illustrations of gross pathology are the best feature of this book.

I regret that I cannot recommend this book as an introduction to pathology.

D. R. TURNER,
Reader, Dept. of Pathology.

"Clinical Workbook in Medical-Surgical Nursing", by R. B. Kurtz and N. F. Miller. Pp. 191. Price £5.25. Published by Saunders.

This American book has eighteen sections, and in each one the medical, surgical and nursing management of a patient with a particular disease is covered.

At the beginning of each section a patient is introduced by name in a short passage about his family, social circumstances and how his illness started. The story of his subsequent admission to hospital and treatment is told briefly in paragraphs which are interspersed in the relevant places with questions to the reader about the incidence and aetiology of the disease, the signs and symptoms and the treatment, nursing care and rehabilitation of the patient. No answers are given other than one concise definition of the disease and space is left for the answers to be written in pencil.

This book gives a useful balanced approach to the care of a patient, always reminding one that he is a person with a family, a job and the need to understand what is happening to him. The questions require the reader to think as well as to look up the answer. However some of them ask for a greater knowledge of diagnostic tests and drugs and treatments than is needed to understand the nursing care, and than would be provided in any nursing textbook in this country. The textbooks suggested in the list at the end of each chapter are entirely American.

The American terminology, spelling and especially drug names in this book make it confusing and in some places incomprehensible. Also the Fahrenheit temperature scale is used, and some investigations are described which are not commonly done in this country. For these reasons I would *not* recommend anyone to buy this book which is well planned and would otherwise be useful.

JULIA FABRICIUS,
Sister.

"Injuries of the major branches of peripheral nerves of the forearm" by M. Spinner. Pp. 278. Price £17.50. Published by Saunders.

This book describes the author's personal experience of 40 cases of anterior interosseous nerve lesions and 100 cases of posterior interosseous nerve lesions, and is expanded to include other, mostly rare, lesions of the nerves of the upper limb. The carpal tunnel syndrome receives scant mention. It is very well written and illustrated and will provide a useful source of reference for the clinical neurologist and peripheral nerve surgeon. It is unlikely to appeal to the medical student or general physician. The clinical neourophysiologist will find that his contribution is given short shrift.

R. A. C. HUGHES,
Consultant, Dept. of Neurology.

"Gynaecology Illustrated", 2nd edition, by Garrey, Govan, Hodge, Callander. Pp. 490. Price £6.50. Published by Churchill Livingstone, 1978.

This is the second edition of a soft-cover book that has proved popular with medical students since it first appeared in 1972. As the title indicates the format is basically pictorial, and in places tabular. The accompanying script is brief, often little more than note form, and therefore tends to be dogmatic. Provided the reader appreciates this point, it can only make for easier digestion at M.B. level. The section on irradiation is particularly clearly presented to simplify the underlying principles of treatment, and as such could well be of assistance to students in disciplines other than gynaecology. If any criticism is to be levelled, it would only be to say how regrettable it is that the book will not quite slip into the white coat pocket for dipping into. However, at £6.50 it is still a good investment even if most of its life is spent on the shelf.

T. M. COLTART,
Director, Dept. Obstetrics.

"Gynecology", 2nd edition, by L. Parsons and S. Sommers. Pp. 1660 + xxxii. Price £35. Published by Saunders, 1978.

This is a *magnus opus* dedicated by the authors to their wives, and if they all wish to remain on speaking terms, I believe with good reason. Illustrations, albeit of excellent quality, are sparse, leaving the bulk of the book as solid verbage, the lay-out of which is virtually guaranteed to trigger off a narcoleptic attack if read for more than a few minutes in warm comfortable surroundings. Many of the subjects are dealt with in question form, such as "What is the malignant potential of the granuloma cell tumour?", which is helpful provided that the point one wishes to establish is put forward as one of the questions. Needless to say this is not always so, in which case one is left searching around for the information required and this can be tedious. The bibliography is good, especially for persons involved in research or those planning to write review articles. Beyond these limits, with the possible exception of candidates sitting the MRCOG examination, I feel it is difficult to justify at £35.

T. M. COLTART,
Director, Dept. Obstetrics.

"Fundamentals of Epidemiology", by D. R. Peterson and D. B. Thomas. Pp. 97. Price £7.95. Published by Lexington.

This book lives up to its title and presents the basic vocabulary of epidemiology in a reasonably satisfactory manner, even with a little wit, albeit of a venereal variety; thus "there are diseases which may be contracted de novo, again and again, under propitious circumstances (gonorrhoea for example)" and "Sexually exuberant ships' crews have been reported to have had venereal disease rates (gonorrhoea) in excess of 100% during a specified time interval." Of course, being an American book they do not use the diphthong, but how many medical students would notice that? The book is more expensive than its British competitors and less comprehensive than, for instance, "Epidemiology in Medical Practice". However, it does have a number of questions and problems (with the answers) which test comprehension and is valuable for that alone. At £7.95 I would not recommend it as a good buy for students, but suggest that it would be valuable for pre-examination revision and for self-testing in the Library.

J. JARRETT,
Dept. of Community Medicine.

"Practical Nurse Nutrition Education", 4th edition, by A. D. Shackleton and C. L. Poleman. Pp. 319. Price £6.80. Published by Saunders, 1979.

It was a pleasant surprise to discover that the contents and style of this book are much better than the syntax of the title would suggest. The book is divided into three sections, dealing with normal and therapeutic nutrition and with food preparation and service. It is essentially a practical book with considerable detail on menus, cooking, food amounts, economic purchasing, etc. To some extent the value of this aspect is lost on the reader who does not reside in the United States, as foods, measures and legislation all refer to those found and used in the United States.

Brief, but helpful, summaries of the physiology, pathology and clinical aspects of health and disease are included, mostly in tabular form and this has forced the authors to compromise occasionally on fact. The coverage on diet in surgery was very poor and occupied one page only, and this despite the book now being in its 4th edition. Does this reflect the authors' view that nutrition in surgery is of little consequence or are surgeons reluctant to accept the advice of dietitians? Also it would have been helpful to have included some guidance to the nurse on intra-venous nutrition.

It is difficult to know what kind of reader would find this carefully prepared and practically useful book of greatest help. It is too detailed for a nurse but could be useful as a reference source, it is not detailed enough for a dietitian, and the sections on therapeutic diets would limit its value to the home economist.

I. MACDONALD,
Professor, Dept. of Physiology.

"Respiratory Pharmacology and Therapeutics", by Irwin Ziment. Pp. 519. Price £20.75. Published by Saunders, 1978.

It is an interesting idea to write a book about drug actions on a particular organ or system, but it must be hard to know where to stop. In this book about respiratory drugs, there is an introductory chapter on general pharmacology (dealing with such topics as drug administration, metabolism and excretion) and sections on drugs which might depress respiration which include descriptions of the narcotic analgesics, major tranquillisers, antidepressants and anxiolytics. In addition the author has put in a general respiratory section with descriptions of the O_2–Hb dislocation curve and the factors which can influence it. Nevertheless most of the chapters are concerned with the drugs used in treating respiratory disease. There are good practical chapters dealing with sympathomimetic drugs, phosphodiesterase inhibitors and disodium cromoglycate. The chemical and other mediators of bronchospasm are also dealt with admirably. There are some difficulties in the chapters on steroids and antimicrobial drugs, in that many of the general properties of these substances are included—which makes for rather tightly packed sections.

On the whole this book is an excellent account of drugs used in respiratory disease. It provides a comprehensive account of (at least) the majority of relevant drugs available in the United States. A particular strength is the coverage of fringe areas—such as drugs which modify respiration and agents used for upper respiratory disease—which are not dealt with elsewhere in a single book.

R. G. SPECTOR,
Professor, Dept. of Pharmacology.

"The Pathogenesis of Colorectal Cancer", by J. L. Bennington. Pp. 162. Price £17.50. Published by Holt-Saunders.

This multi-author monograph is written in a clear and concise manner, and deals with various aspects of colonic polyps and large bowel cancer. It focuses its attention on the premalignant adenomatous polyps and their progression to frank carcinoma.

When I first picked up this book, I wondered if it was necessary to document a process which is now generally accepted by pathologists and surgeons. However, I found that the contributors' scholarly approach to the problems associated with large bowel polyps makes a very readable book and is both stimulating and educational.

I recommend this monograph to all histopathologists and surgeons dealing with large bowel disease.

D. R. TURNER,
Reader, Dept. of Pathology.

Correspondence

In defence of the Spit

Sirs,

Below are the results of a survey of refectory prices at Reading University and at 27 Schools, Institutes and Halls of the University of London, excluding Guy's, as at 26th February 1979, showing the lowest, highest and the average price of a selected list of items. To the right are the corresponding Boland House Cafeteria prices for these items, which are still the same.

Item	University Survey 26th February 1979			Boland House Cafeteria 26th February 1979
	Low	High	Average	
	p	p	p	p
Soup 1/3 pt.	8	12	10.2	**7**
Bread Roll	3½	7	5.4	**5**
Butter x 8 gms.	1½	4	2.5	**2**
Coffee—Fresh 7 oz.	8	14	10.3	**9**
Coffee—Instant 7 oz.	7	11	9.3	–
Tea 7 oz.	5	10	7.9	**6**
Roast Beef 2 oz. cooked	30	48	40.1	**30**
Roast Lamb 2 oz. cooked	32	48	40.7	**30**
Beef Sausages (2)	9	30	20.0	–
Pork Sausages (2)	9	35	22.1	**18**
Veal & Ham Pie with Egg	19	32	26.8	**28**
Steak & Kidney Pie—individual	23	36	27.6	**29**
Steak & Kidney Pie—5 oz. portion	26	60	40.2	**28**
Chipped Potatoes 4 oz.	12	15	13.3	**11**
Vegetables 4 oz.	10	15	12.4	**9**
Sweets—Hot	11	18	14.1	**10**
Sweets—Cold	11	18	13.7	**10**
Fried Cod 4 oz. raw	18	64	41.0	–
Fried Coley 4 oz. raw	36	45	39.6	**25**
Fried Plaice 4 oz. raw	21	68	43.8	**37**
Sandwiches—Meat—Round	12	28	22.5	**15**
Sandwiches—Other—Round	12	28	21.0	**12, 15, 17**
Filled Roll—Meat	10	22	15.9	**13**
Filled Roll—Other	10	22	14.6	**10, 13, 15**
Fried Egg	9	15	11.3	**7**
Yoghurt—Fruit	11	16	13.1	**13**
Yoghurt—Natural	11	16	12.7	**12**
Sausage Roll	6	15	12.6	**9, 11**
Cornish Pasty	13	34	23.9	**23**

J. C. HOUSTON,
Dean.

The Snowflake Ball—Again!

Sirs,

I am sorry to say, but I found it no great surprise that my letter in the March *Gazette* has received no reply. I have been informed by the Editors none has been received for this edition.

Where are the several hundred pounds not paid to various performers?

Why have the people concerned been so reluctant to give any explanation?

What is it that needs to be done to get an answer from these people—so-called organisers — about why things went wrong at the Snowflake Ball and more especially, what has been done with OUR money?

Yours,

an impatient (after almost 6 months),

R. J. PECK

Boland House,
Guy's Hospital,
SE1 9RT.

Wilfred E. Griffin

Sirs,

My cousin Dr. Patrick Griffin tells me that he informed you of the 100th birthday of my father Wilfred E. Griffin. I now have to inform you that he died on Good Friday—about three months after his birthday.

Yours faithfully,

Mrs. KATHLEEN THOMAS

Elenors,
Quarr,
Ryde, I.W.

Earnshaw boobs

Sirs,

As a non rugby playing member of the medical school I feel Jonathan Earnshaw's remarks in the Sports Report (April 28th issue) cannot go unquestioned.

He implies that those who don't play rugby or soccer tend to be socially inadequate with patients. Where is his evidence for this? He also says that the rugby player has the advantage of "confidence", even if his factual knowledge does not compare with that of his "hard-working and introverted" colleague. Surely such self-assurance is dangerous?

Does he realise that over half of the student intake are now female, not picked for their performance on the rugby pitch, but not totally lacking in character or common sense either?

Yours faithfully,

SARAH PEARSON

Boland House,
Guy's Hospital,
SE1 9RT.

Air of Confidence?

Sirs,

I thought this may be of interest to you as an *obiterdictum.*

Well known Guy's transplant surgeon overheard discussing transplantation with a visiting nephrologist.

"Trouble with transplantation is you haven't the slightest idea what you're doing".

Yours sincerely,

C. B. B.
(an Ex-Editor)

Guy's Hospital,
SE1 9RT.

Fly the Flag

Sirs,

How sad that the great Guy's Hospital should fail to acknowledge April 23rd by flying the flag.

Perhaps the Dragon has won after all.

Yours faithfully,

St. GEORGE

Guy's Hospital,
SE1 9RT.

Rugby History

Sirs,

It was with great interest that I have read the history of Guy's Rugby, admirably compiled by Tom Lewis. His detail is truly amazing but there appears one omission which happened during my most enjoyable time at Guy's. Did not Tom Lewis himself play in an England Trial held at Portsmouth in 1948?

Yours faithfully,

MICHAEL GRAY

P.S. Ecksteen, de Villiers, Rademan—*what a back row!*
52 Chantry Road,
Bishop's Stortford,
Hertfordshire CM23 2SG.

Guy's National Champions

Sirs,

Much to their intense delight, Guy's medical student Paul Holmes and his Guy's nursing-tutor wife Kathryn were awarded the "Best Layout" cup at the 1979 EXPO EM Model Railway Exhibition at the Great Western Royal Hotel, held on Saturday and Sunday the 12th and 13th of May.

Paul and Kathryn were invited to display and work their completely authentic representation of Shipston-upon-Stour station as it would have been in 1928—in May to be precise! Their layout was one of a rigorously selected half-dozen or so, representing the country's finest layouts, making them the 1979 National "EM" Champions.

Their work may be well known to some of you; those of you who have seen it will be able to attest to the incredible attention to detail and the sheer finery of the craftsmanship. Literally thousands of hours go into researching the area, taking photographs, sketches and measurements and then committing engine sheds, goods yards, platforms, etc., to perfect 4 mm to the foot scale models—all scratch built of course. Finishing touches such as moss in a gutter, a broken window, dirt on the cornice of the engine shed, must all be faithfully reproduced.

The locomotives (never say trains in the presence of such cognoscenti) are built from kits or scratch; likewise for the wagons and coaches. Again the same attention to detail is called for and but for the lack of those unmistakeable noises that surround a station or goods yard, you could almost be there—the Great Western saddle tanks shunting up and down the line, the myriad passengers clambering hurredly on or off those distinctive chocolate and cream coaches, the Foden steam lorry collecting a consignment of coal—all amidst the quiet rolling backdrop of rural Warwickshire.

Yours faithfully,

TIMOTHY HOULDING

Boland House,
Guy's Hosyital,
SE1 9RT.

Playgroup volunteers needed

Sirs,

A group of students from different areas in the Hospital have been running a recreation evening in Guy's Tower for children who are too old to need (or want) a six o'clock bedtime. This scheme has been running succesfully for over a year and we are proud to know it is the only one of its kind in the London area. At the moment we have a problem —the founder members of the group will shortly be embarking on clinical studies, and the year below are about to have major examinations. The time table at the moment is being manned by 18 students on a 4 day week—Monday to Thursday. As well as our present problem we always have the difficulty of keeping the playgroup going during the long summer vacation when so many of our students are miles away from Guy's. It is for this reason we would like to attract people from other areas in the Hospital.

If you like children, if you can be especially patient with sick children and can spare one evening either every week or once a fortnight please contact me and I will be happy to furnish further information. Alternatively contact Mrs. Marie McGlone, at 4 St. Thomas Street, or 'phone extension 2229.

Yours sincerely,

LAWRENCE MAULE

Boland House,
Guy's Hospital,
SE1 9RT.

Mr. Rex Lawrie

Sirs,

As the Nurses' League Journal only appears once a year, I would be very grateful if you would publish this letter in the Gazette to clarify one or two points made in the 1979 League Journal about my husband and myself.

Rex Lawrie, M.D., M.S., F.R.C.S., F.R.C.P., London University Gold Medallist, of the Middlesex Hospital, worked with the late Patrick Clarkson in the North African and Italian campaigns and was mentioned in dispatches for his work at the battle of Cassino. He was appointed to Guy's in June 1948 —a pre-N.H.S. appointment. After nearly thirty-one years of surgery and teaching, and having become Senior Surgeon at Guy's, he accepted an invitation from His Highness the Sultan of Brunei to become General Physician to His Highness, Director of the New Hospital Project and Director of Postgraduate Studies, and he retired from the N.H.S. on March 31st, 1979.

I of course accompany him and am lucky enough to have a post there myself—not "taking care" of the Sultan's Household, but helping to provide medical care for all the Royal Ladies and their children.

It was kind of the Journal to refer to my links with the Medical Women's Federation. The M.W.F. was founded in 1917 when I was not of an age, alas, to have been able to be a founder member. But I am very proud to have been its President and also proud to have been a member of the Guy's Ladies' Association and for so many years to have been an Honorary Member of the Guy's Nurses' League.

We continue to be a Guy's family and it is a source of great satisfaction to us that our daughter, Christina, trained at Guy's, is now Consultant in Rheumatology to the Royal E.N.T. Hospital in London.

JEAN LAWRIE, C.B.E., M.B., B.S.

c/o Office of General Adviser to
His Highness, The Sultan,
Istana Darul Hana,
Brunei.

Sport

It gives me great pleasure . . .

I am also very glad to take over from Jon Earnshaw as Sports Editor! Jon has always provided a lively sports section, and was a prominent sportsman at Guy's during his time here. I hope his last editorial has provided much discussion. I believe that healthy sports clubs are good for Guy's as well as being healthy for the individual—but more of that later. Anyway, farewell and good luck to Jon—he's always been the kind of person to offer you a drink and then direct you to the nearest Off-Licence; and with an attitude like that he won't go far wrong once he's qualified.

While I'm thanking people, and before Ade and Phil reduce the number of sports pages, (they're the Editors in case you'd forgotten), I would like to thank everyone who writes match reports (especially those making the copy date). I've written a few myself and realise how hard it is to remember all the match details, to mention everyone in glowing terms, and to write it as though the team should have won, even though you've forgotten everything in the post match alcoholic daze, the team played badly and lost by 5 goals/8 wickets/30 points. Anyway thanks very much and I'll be glad to receive any match reports about any sport (well almost any) involving Guy's.

Sport at Guy's seems to be healthy at the moment. Sadly however, our most famous club seems not to be living up to its standards of earlier years. I refer of course to the Rugby Club, although results have not been forthcoming for a number of years, interest now seems to have dropped off alarmingly. Two seasons ago, it was not unknown for seven teams to play on the same day. Last season it seemed on some Saturdays that Guy's had trouble raising a second team. I hope that somehow a spirit can be revived to make Guy's Rugby Club truly a Club and not just a collection of teams. There's always next season and with the Fresher's team reaching the Gutteridge Plate Final, there is room for optimism.

However other clubs in Guy's seem very healthy indeed. The Soccer Club ran a third team for the first time last season, very successfully, and following the Germany tour, club spirit and optimism is high. The Hockey Club have done well this season being promoted to Div. 2 of the Kent league with a 100% record. They also run a fairly successful second team (see report below and also the 1st's tour report). The Water Polo team is also in a very healthy state at the moment, winning the U.L. Cup and finishing high in the league. The Squash Club had a mixed season winning the U.H. Cup but doing less well in the league. Let's hope that Guy's can build on these fine achievements next season.

However now the Summer is upon us, and I hope you will all be taking advantage of the (occasional) fine weather to fight your way into the Tennis and Cricket teams (In between working for exams of course). The Cricket 1st XI have done very well so far winning five out of five matches (no draws!).

One side of Guy's sports however seems sadly neglected, both in participation and publicity—the Ladies. Half of the intake at Guy's is now female and yet Guy's seems to have relatively few organised Ladies' teams. One exception to this is the Ladies' Hockey team who have finished high in the U.L. league in the last few seasons and recently narrowly lost in the final of the U.L. Cup. Swimming and Water Polo also

seem to be fairly healthy at the moment. However, there seems to be a vast reservoir of talent waiting to be tapped if someone has the initiative to stimulate our sporting ladies.

Anyway, good luck to all teams for next month. To all the cricketers a straight bat; the tennis players, a stiff wrist and the swimmers a powerful stroke.

G.D.C.

P.S. The captain of Guy's ladies hockey has never had her name printed correctly it is in fact Kristin Pagano (the well known typing error).

CRICKET

v Templesheen Eccentrics — Guy's won by 5 wickets

Five wins in five matches is one of the best starts that Guy's Hospital C.C. has made to the season for quite a few years. After four cancellations Charlie "Big Bob" Tunnadine led out an eager but ill practiced ten men—thanks go to Andy Mitchell for turning up only three hours late.

The weather was fair and the sun was seen shining. The Captain of Templesheen Eccentrics won the toss and elected to bat. Two very tidy opening spells of bowling by "Big Bob" and Paul "Smoothie" Shepherd left the opposition at 20 for 2.

One of the substantial group of freshers playing cricket this season, Niaz "Coke" Karim was given the opportunity to demonstrate his bowling skills, it was only after the first over when someone pointed out that it would be more effective if the ball only bounced once that he gave a tidy bowling spell returning 3 for 28.

Persistent inquiry by James "Fonzie" Fellows-Smith gained him the opportunity for a couple of overs to close the already depleted innings of the opposition and effectively removed their most consistent batsmen in his second over.

Facing a total of 81 the Guy's team were feeling confident at tea. Peter "only broken his nose 17 times" Jolliffe opened the innings and quickly set about the opposition bowling. Unfortunately for Jolliffe, Dave "Trigger" Greenaway was entrusted the job of umpire and gave him out to a ball that should have been heading over square leg for 6 when it hit the pads down the leg side. Anyway "Trigger" gave the side another shock when he gave his second lbw decision and was quickly replaced and the runs were fairly quickly obtained by Big Andy "Meglo" Mitchell, Smoothie Shepherd and Big Bob Tunnadine.

Thanks go to Gary Calver for exposing himself to all and sundry (his trousers split).

v London Hospital — Guy's won by 29 runs (May 6th)

The second match was on Sunday, May 6th at H.O.P. and was an all day game. I thought this was an error when (with only 9 men at the start) the London Hospital's two openers had Dave "Teddy Bear" Hett and Mick Powell out in the first few overs. Indeed in a devastating opening spell Guy's stood at 32 for 8. However they hadn't reckoned with Liam "Pegleg" Broughton who dispatched the 2 spin bowlers brought on, out of an act of mercy it seemed, for 30 very quick and extremely useful runs and brought some respectability at 79 all out. The London's batting line up looked formidable but sadly crumbled to a useful opening attack of Williams 6–17 and "Big Bob" Tunnadine 4–40. As the game finished at about 4 o'clock it was decided to have a beer match of 20 overs a side and this provided some of the most amusing scenes of the day because everyone in the team had to bowl two overs. The opening spell down the hill was by John Twomy with such pace and fire off his 30 yard run up. He completely mystified the opening batsmen by bowling him 2 full tosses, being hit for six and four, and then clean bowling him with the third full toss. Many of the fielders suffered a lot of pain due to excessive laughing at the bowling attempts of Mark Powlson but we were grateful for him turning out at the last moment and he was good in the bar.

"Teddy Bear" Hett must be remembered for saying that he had to leave after the match and was seen staggering towards his car at 9.30 looking as usual unfit to drive his car.

v Streatham Police — Guy's won by 6 wickets

The third match of the season was also at H.O.P., on Wednesday, May 9th against Streatham Police. The weather was fine and the pitch as usual looked very sporting. The police won the toss and batted first. The usual tight fielding and excellent catching was not at its usual high standard and explained the total of 94 that the police reached. Alistair "once a week" Jacks produced a fine bowling spell to get 5–30 and Williams narrowly avoided his second jug by getting 3 wickets in 4 balls.

The batting was monopolised by Alasdair Jacks who hit everything off the middle of the bat and nearly every shot screamed for four. He seemed in total control and reached 77 not out and but for a few silly shots we would have won by 10 wickets. Alasdair's excuse for only half a jug was lack of funds (this sounded a bit suspect) but it cannot be denied it was a one man match.

v Carnegie — Guy's won by 98 runs

The fourth match was against a wandering West Indian side called Carnegie. They came with the reputation of easily beating Guy's in the last three encounters and a certain member was heard to say we didn't stand a chance. On the day of the Cup Final we couldn't understand why they elected to bowl. We started steadily and the downfall of the early batsmen was because the speed of the ball off the pitch was very unpredictable and often they had played shots before the ball arrived.

In his previous innings "Big Bob" had shown us his striking capacity with his very straight swing of the bat, ideally suited to the H.O.P. pitch. He took full advantage of some wayward bowling and proceeded to "tonk" the bowlers all over the field with some magnificent sixes. He raced to his fifty to everyone's delight and with his eye in, and swinging freely proceeded to 92. Unfortunately due to a change in the rules he thought he was out when he hit the ball high into the outfield and was caught but the fielder ran over the boundary. The feeling among the troops was that he was trying to avoid the double jug. However it was a memorable innings and left Guy's in the very strong position of 176–6 declared. Mention must be made of an extremely diligent supporting innings of 37 not out by John "I'm not a Pom" North.

The West Indians innings started shakily when they lost a wicket in the first over and never really recovered to look at all like winning and the wickets were shared fairly evenly between Tunnadine 3–32, Williams 3–27, Karim 2–13 and "Fonzie" 1–5. Yet again the scenes in the bar were memorable and a very enjoyable evening was had by all.

v U.C.H. (U.L. Cup) — Guy's won by 42 runs.

The fifth match was in the U.L. Cup against U.C.H. on Sunday, May 13th and their first psychological weapon was to say that we would have to start two hours early to accommodate their two fast bowlers. The day started well when we arrived at the ground to receive a phone call from the Captain who had inadvertently run into the car in front and damaged his car so badly, he had to get a taxi to the ground. On paper we had by far our best batting side of the season and could have batted to number 10 (apologies to Mick "Chopper" Corlett who was good enough to turn up at the last minute).

We finally started at 12.45 and thought as usual with Guy's cricket a strong side would fair very badly and when "Fonzie" Fellows-Smith was extremely well caught in the second over, Alistair Jacks went cheaply and when Mike Glover was bowled by an extremely quick and accurate yorker I thought it would be another batting failure.

Rick Plowman playing his first match put his head down and played steadily. Pete Jolliffe obviously decided that after running 8 quick singles that his very middle age frame was not up to it but admittedly was out to a very good ball.

The first change bowler was a left-hand off-spinner and after having one wild fling and fortunately being dropped started timing the ball sweetly and Andy Mitchell scored 44 runs.

Charlie Tunnadine and Ian Leonard nudged the score on another sixty runs with some very useful edges and the inevitable sixes. The 172 for 8 declared off the 40 limited overs appeared to be a useful score but the game proved to be the closest of the five. The first couple of wickets fell cheaply to Jacks and the game seemed to be over as they slumped further and further behind the asking rate. A very useful partnership by their middle order batsmen realised seventy runs and they seemed set to make a close finish of it. However almost the best catch of the season was taken by John North in the outfield when he ran from long off to long on and took a catch off a lofted drive at full stretch whilst still running. Very next ball the steadiest batsman swung across the line to a straight ball and was bowled.

Mike Glover bowled extremely tidily and was unlucky only to end with figures of 3 for 31 having several catches dropped. James "Fonzie" Smith bowling his leg breaks was getting a considerable amount of turn—"on the third bounce" and we thought they should be made to try a little harder to score their runs.

In the final analysis the wickets were shared evenly between Glover, Jacks and Williams and a good all round team performance brought a well deserved victory.

Indeed the strength on paper of a few of the sides has left something to be desired but actually as a team have performed very well and in the final analysis this is what counts.

It seems a great shame that with a home ground as close as Honor Oak Park and a lovely ground with very hospitable staff in Eric and Joyce Dann that at least a few of the apparently apathetic Guy's students could not come and watch one of their most successful teams.

D. N. B.

TENNIS

The tennis season for Guy's has started slowly with our opponents cancelling two matches. However the First team have comprehensively beaten Barts, whilst the Second team have narrowly lost to Westminster Firsts.

Although the tennis trials were unfortunately rained off, anyone keen to play in any of the numerous league and friendly matches can contact me.

Finally, don't forget the Mixed Doubles tournament at H.O.P. on June 2nd, which is open to everyone.

Andy Morgan

HOCKEY

1st XI tour to Folkstone

Once again the 8th oldest club in the Folkstone Festival arrived with cheque books in hand and overdrafts arranged to be greeted with the excellent news that the hotel bar had been extended. This was to enable more able bodies to prop it up, as the Radley Galleons were also in the hotel. After a refreshing pint, the first of many, the team travelled to the ground.

The first match was against Nottingham University on what could only politely be described as a cabbage patch. As Nottingham have 6,500 students to choose from and we have barely 1,000, a tough match was in prospect.

Having not played for six weeks the first ten minutes were very ragged but gradually Garth Saward and Mark Harris at full backs got it together and Guy's began to threaten with fast breaks; one of notable speed nearly brought the first goal—Hett passed square ball to Barris who struck a fine corner flag ball. A fast cross from Jones resulted in Wyeth crashing a shot just over the bar. With Hett strong at centre half and the insides and Rick Plowman working hard Nottingham were under pressure. Half time was reached still scoreless with Rob Forber putting in a strong claim for the T.T. tie by allowing the right winger free shots which Pascoe bravely saved.

The second half was similar but in the last ten minutes a good move by Nottingham resulted in a goal for their No. 8. Guy's had one or two late chances but were unable to score. Overall this was a good result against a University as strong as Nottingham. In the evening that followed trousers featured as the Galleons tried hard to play fizzbuzz, but are still at the C.S.E. stage, as is Hett's organ playing. Eventually our president ordered an early night as an International match was in prospect the next day.

With Summer weather dawning and Hett missing from breakfast there was a discussion on the day's match. A quick bar visit was required when we read they had two internationals. Eventually at 4.30 on N.W.II a sense of anticipation for a great sporting occasion was in the air.

The game started with Guy's roaring into attack and for 10 mins. they bemused the arm waving Italians with devastating hockey. Many good chances were created after some slick hockey between Plowman, Jones, Wyeth and "Coke" Karim. The Italian 'keeper saved an acute angle shot from Jones after a great pass from Hett. Steve Flint, obviously short of a tie, managed to kick the ball when given some excellent scoring chances. But in the 31st minute came the goal of the tournament! Soughpal Singh sent Flint away and somehow he avoided kicking it as he centred. The ball flew across the "D" for Jones to defy pythagorus and score from a very tight angle. Guy's were winning!!

In the second half we tired and the opposition who had plenty of skill attacked well. Pascoe saved well from short corners and horizontal Saward cleared off the line. Singh made some good tackles but was conserving energy for a nocturnal performance. Now with Guy's running out of steam and one player in particular looking a little anaemic a substitution was necessary! Still we hung on to win and overall we deserved to. Well done lads!!

So to the bar where the T.T. donned the tie and bought his jug with pride (unfortunate. Never!!). When our Italian opposition arrived we found their English as deficient as Hett's moustach, but with Singh plying them with beer and shouting "The Anglasia bira you drinka" fluent Italian was learnt in a few hours! The quote of the night came from the

Italian skipper who was overheard to say "I musta chargea my wata" whilst looking for the toilet. Roberts gave a textbook demonstration in the rapid deglutition of liquids as John tried to shake his hand. Surely he got the wrong idea? At the end of the night a hassled oppo. captain managed to make them leave with cries of "Arividercci!! until September". But that is perhaps another story.

The Sunday match was against old favourites from a few years ago; Old Princess from Holland. The game started without Hett and Flint as they seemed to have other arrangements. But with side line encouragement from Plowman Guy's held firm. Hett eventually arrived and we began to play hockey. The Dutch, being much older than us, played a sensible passing game just aimed to tire us out and foolishly we took the bait. The game was not a classic and we ran out loosers 2–0 through one lucky and one great goal. Had it not been for some great goalkeeping the score might have been more. However we did play some fine hockey and Guy's were unlucky not to score when we hit the post.

That evening was very social as all the Dutchmen spoke perfect English and as they had brought their wives we were all well behaved. Later on though the Italians, surely gluttons for punishment, came along to see John Pascoe (the birthday boy) put on the shelf in a big way. In the depths of the night we heard William Harvey crying out for refreshment but as we obliged we met a Folkstone team dressed in blue who were not quite so keen on the idea.

Finally to Monday with wallets bare and neurones lacking we took the field against a strong Eastbourne side. The ball had obviously shrunk as had our sticks but our feet seemed giant sized. Eastbourne soon put two goals past us through foolish mistakes and double figures looked on. But with sheet determination and some very acrobatic work from Shelf Pascoe Guy's held firm and pulled one back with a great shot from Plowman. The second half was the same with Pascoe, Hett, Saward and Barris playing well. Soughpal looked a little better as was his hockey. Eastbourne only managed two more and a 4–1 loss was creditable against top Sussex league opposition.

So concluded a very successful Folkstone and indeed season. The hockey Guy's played over Easter was tribute to such a small club and must argue well for future years. It must be remembered that Folkstone is the best festival in the country and if Guy's can continue their standards, there is no reason why we should not be going there for many years to come.

After such an excellent season the whole team *must* congratulate David Hett whose sheer enthusiasm and effort has generated a very good young club which surely must go higher in both league and cup. Well done Dave!!

D. Jones.

Team: Pascoe, Saward, Harris, Hett, Forber, Singh, Barris, Jones, Plowman, Wyeth, Karim, Flint and Hoffonier.

2nd XI Summary

The 2nd XI started the season with a strong squad of some twenty players, including a new goalkeeper, Neil Oastler, three full backs, Chris Darby, Mike Craigen and Andy Emmerson; the half backs were Matt Kiln, Martin Vallis, Dave Maxted, Andy Lawson, and Sukpal Singh occasionally borrowed from the 1st XI. The forwards were Julian Hart, Clive Straker (a South African on electure), Seb Johnston (the new captain), Nick Mimms, John Wilde, Alex Williams (when not playing football) and later in the season, Shiraz Gulami.

The team played ten matches, of which we won six, drew one and lost three. Many matches were unfortunately lost to the weather. 34 goals were scored for and 18 against. The scorers were Seb Johnston 11, John Wilde 5, Shiraz Gulami, Clive Straker and Alex Williams 3, Julian Hart 2, Andy Lawson, Nick Mimms, Dave Maxted and Simon Wyeth 1 each. Duncan Jones, borrowed from the firsts for a match scored a hat-trick.

The season was actually fairly successful, as of the matches lost, two were against far superior clubs, arranged as replacement fixtures, and the other we lost 1–0 while having the handicap of only 9 players, one of which was a goalkeeper without pads! The most pleasing feature was the fact that we defeated many teams to whom we had lost the previous season.

The season was marred, by our losing of the Junior Hospitals Cup that we have held for the past 5 years. We were drawn against St. Thomas's in the first round, always a difficult game as their side included 5 first team players. They were also keen to avenge their 3–2 defeat in the previous season's Cup.

Unfortunately, for this game both our first-choice goalkeepers were unable to

play, and so Peter Joliffe very kindly agreed to help us out. He had a very difficult task, though, as he had not played in goal for seven years. The match was very close, with the lead changing hands three times. Tommies eventually won 4–3. The scorers in the game were John Wilde, Simon Wyeth and Seb Johnston.

We are now looking forward to a big intake of freshers, and hope to start a 3rd XI. The second XI will hopefully be taking the place of the 1st XI in the league, as they were promoted this season.

Thanks to Rog Dickson for turning up to the practise matches and to Tim Whitbread for saying he would but never bothering.

Seb Johnston (Capt.).

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PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Diploma of Licentiate in Dental Surgery

J. A. Bell
M. D. Boote
J. M. Bowen
A. M. Clover
M. T. Coppen
M. P. Delahaye
H. E. Evans
A. S. Gamlen
R. G. Hahn
J. A. Harrison
A. J. Hedger
S. G. Hill
A. Inamdar
R. L. V. Johns
P. J. Jones
S. P. Jones
T. Listerud
D. J. Mehigan
P. A. Norton
A. M. Peel
C. A. Pritchard
E. Rapaport
J. L. Rees
E. J. Whaites

CHRISTENING

WHITE, Morwenna Jane. Daughter of John and Joanna (neé Bromley) of Toronto, Canada, in Guy's Hospital Chapel, 22nd April, 1979, by the Rev. R. Kempster.

MARRIAGE

MAY 12th, 1979. Dr. R. Coates to Miss P. P. Linton at Oxford.

PERSONAL

DARTMOUTH, Devon: Associate required for hard working, hard playing, family dental practice. Suitable newly qualified, particularly sporting types. Starting June/July. Write: Lloyd-Edwards, 83 Victoria Road, Dartmouth, giving details.

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LOCUM REQUIRED for one month from last week in July for single handed practice in Liberal Gulf State of Sharjah, to cover quiet month of Ramadan. Remuneration at rate of £10,000 per annum with no local income tax nor currency exchange regulations. Air fare and free air conditioned accommodation and use of car. Facilities for all social and sporting activities Please reply by airmail to M. J. Burke, c/o McNeill and Company, P.O. Box 729, Sharjah, United Arab Emirates.

ENGAGEMENT

THE engagement is announced between Miss Catherine Lockwood, medical student and Peter Robinson, dental student.

CHANGES OF ADDRESS

KILBY, J. V., The Old Bake House, 42 High Street, Kimbolton, Huntingdon, Cambs. PE18 0HA.

MARIN, G. A., M.D., F.R.C.S., 176 Maple Street, Massena, New York, 13662.

PAINE, D. T. H., M.D., P.A., 608W Carolina Avenue, Hartsville, South Carolina. 29550.

RAZZELL, Daphne. The Olives, Buxted, East Sussex.

RAZZELL, Philip, 21 Thakeham Close, Sydenham, S.E. 26. 01–778 4377.

THOMSON, R. G. + C., Medical Centre, Room 2108, 21st Floor, Hilton Hotel, Sydney, Australia.

TRIST, F. H., L.D.S., R.C.S., 31 South Cliff, Bexhill-on-Sea, East Sussex.

DEATHS

FRANKLIN, Hugh Reginald William. Qualified Guy's 1937, M.B.B.S., F.F.A. Died in Georgio, U.S.A. on November 27th, 1978.

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SPORTS CORRESPONDENT — GARY CALVER
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PHYSIOTHERAPY CORRESPONDENT — RONALD COOPER
MANAGER — PAT POULTER

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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30 JUNE 1979 — VOLUME 94 — NUMBER 2293

Published Monthly at Guy's Hospital, London.

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Passim

Que sera sera

The School Council has voted by 17 votes to 14 to discontinue the 1st M.B./1st B.D.S. course at Guy's. The decision comes as a considerable disappointment to those who consider that doctors and dentists should not be drawn from an educational stereotype. The academic and clinical performance of preliminary year students has generally been higher than their direct entry counterparts, and many distinguished *alumni* including the present Dean entered via a preliminary year. The argument for scrapping it appears, as usual, to have been financial, (to allow more money for other pre-clinical disciplines).

Presumably the preliminary year was regarded somewhat as a luxury rather than as a necessity, and so perhaps it was to the view that doctors and dentists should be trained as economically as possible. The matter however, has wider implications.

Consider the present direct, or science 'A' level entry. A good biology 'A' level correlates well with success in medical and dental courses, while mathematics for example, correlates only poorly. This has led some selectors to urge that biology should be a compulsory entrance subject. At the moment this would leave the candidate with an option of two subjects from physics, chemistry or mathematics and the choice would invariably be made in the fourteen to sixteen year age group. But quite apart from the problem of deciding exactly where young students' abilities lie is that of whether the traditional combination of Phys. Chem. Biol. is the most appropriate one anyway.

Research, notably by Professor Liam Hudson, has shown that the abilities required for biology and medicine occupy a halfway house between those required for subjects such as history or English, and more diametrically, mathematics or physics. Thus apart from imparting knowledge and acting as a selection barrier 'A' levels may also serve a 'diagnostic' function by indicating where in the range of abilities a person lies. Interestingly enough, the standard required to complete the preliminary year is probably not as high as that expected in the corresponding 'A' levels, but this has not been limiting for success in medicine and dentistry.

Now, a candidate with abilities spread through the spectrum who has taken Arts 'A' levels will not register on this 'diagnostic' test, although he would be quite capable of studying medicine or dentistry. The advantage of selecting from students with the ability to study medicine or dentistry but who do not have the traditional trio of 'A' levels is purely cultural and is thus axiomatic. The problem is how to select candidates who are likely to be successful but who have a non-orthodox educational background. Of the traditional 'A' level trio, biology is much the best correlate with success, and therefore it should be possible to select students with a good grade in that subject and any two other good grades. Some restrictions may be necessary, for example those 'A' levels in art which only test ability

at painting and drawing. Perhaps the medical and dental schools should approach the G.C.E. examining boards and determine a suitable syllabus for a "Science for Medicine" 'A' level. In this two-year course could easily be taught all that is now required for the complete preliminary year.

In addition, the loss to research of running down certain pre-clinical departments is an important consideration, as many of the advances in medical science have been from these disciplines.

If we are to lose the preliminary year let us take stock, and better our educational and cultural standards by taking a more eclectic approach to the selection of doctors and dentists. But what price an education?

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News in Brief

The Birthday Honours List

Our heartiest congratulations go to G. D. Gibb, Chief Dental Officer, Department of Health and Social Security, who has been awarded the C.B. in the Queen's Birthday Honours List.

Professor M. N. Naylor

It has recently been announced by the Ministry of Defence that Professor M. N. Naylor has been appointed Honorary Colonel of the University of London Officers Training Corps. Until his recent retirement Professor Naylor was a Surgeon Captain in the Royal Naval Reserve. We offer him our congratulations.

Colgate Prize 1979

We offer our congratulations to Dr. Crispian Scully of the Dental School who has been awarded the Colgate Prize for his paper "Comparative Opsonic Activity in Oral Fluids and Phagocytic Activity of Blood, Crevicular, and Salivary Polymorpho-nuclear Leukocytes in the Rhesus Monkey".

Queen's Award for Longmans

Longmans, the publishers of *Gray's Anatomy*, has just been awarded the Queen's Award for its exports. We are assured that this is very much due to the very considerable success of the 35th edition of *Gray's Anatomy* edited by Professor Warwick and Professor Williams, which appears to have sold particularly well in America.

New Consultant Appointments in the Paediatric Department

Dr. Margaret A. Lynch has been appointed from March 1st 1979 to the new post of Senior Lecturer in Community Paediatrics. Her clinical work is divided between the hospital (Evelina Children's Department and Newcomen Centre) and the community (schools, nurseries and child welfare clinics). Dr. Lynch graduated from Newcastle in 1966, and has held paediatric appointments in Newcastle, Oxford and at Guy's. Her research work has been particularly concerned with child abuse, on which she is an internationally recognised authority. She will continue her work in this field, as well as in infant mortality and "sudden infant death syndrome".

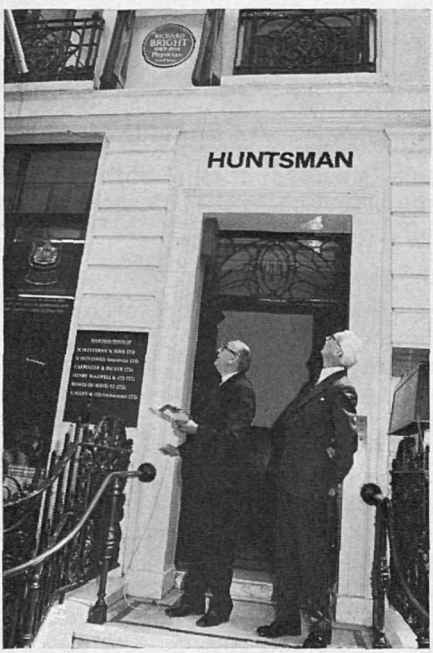
Dr. Gillian Baird has been appointed from April 1st 1979 to the new post of consultant paediatrician with a special interest in development and handicap. Her clinical work is divided between the Newcomen Centre at Guy's and other developmental assessment centres in the S.E. Thames Region; her particular concern is with the regional services for developmental assessment and care of neurologically handicapped children. Dr. Baird is a Cambridge graduate who was awarded First Class Honours in Tripos Part II, and did her clinical training at Guy's. She has previously held posts at Guy's, the Brompton Hospital and Canterbury. Her research interests have been in developmental handicaps including disorders of speech development, and the sequelae of hydrocephalus.

Dr. George Haycock has been appointed from May 1st 1979 to a new post of consultant paediatrician and paediatric nephrologist. He will share with Dr. Chantler the care of the children in the very busy inpatient and outpatient departments in paediatric nephrology, and in the new children's dialysis unit. Dr. Haycock is a graduate of Cambridge and St. Thomas's. After a Senior Registrar appointment in Bristol he spent two years in paediatric nephrology at Albert Einstein College of Medicine, New York, returning to a consultant appointment at Bristol, whence he came to Guy's. His publications have been on renal physiology, fluid balance and renal disease in childhood.

Mr. J. S. Tomkinson

The retirement is announced of Mr. J. S. Tomkinson, M.B., Ch.B., F.R.C.S., F.R.C.O.G., from the Department of Obstetrics and Gynaecology. We wish him every happiness in the future.

Lord Robens unveils a plaque commemorating Richard Bright.



Lord Robens, watched by the Dean, unveils the Bright plaque.

On 9th May, Lord Robens unveiled a plaque above the door of number 11 Saville Row, commemorating Richard Bright who once lived there. Several descendents of Bright were also present at the unveiling.

About this month's cover

This month's cover shows a self-portrait of Joseph Towne at the age of twenty-three which belongs to the Gordon Museum.

Research Fellowship for Guy's teacher

This year for the first time, the D.H.S.S. is funding two Research Fellowships for the Remedial Professions. Fiona Turner, a teacher in the Guy's Hospital School of Physiotherapy, has been awarded one of these Fellowships in order to follow the M.Sc. Biomechanics course at the University of Surrey in September 1979.

David Scrutton at the Newcomen Centre, who successfully completed this course in 1969, and Sheila Kitchen from the School of Physiotherapy who is on the current course, are among the small number of physiotherapists whose qualifications have been accepted for admission to a Masters' Course in a British university.

TV Newsreader visits Guy's

(By permission "Daily Telegraph")

Anna Ford, an ITN newsreader, visited Guy's last month to present the first kidney donor tie-pin to the actor Donald Sinden. Anna, who was the first woman to wear a kidney donor pennant, made the presentation to mark the beginning of a campaign by the National Kidney Research Fund to encourage men to identify themselves as kidney donors by wearing the sun-emblem tie-pin.

The Macdonald Golf Cup

This year's competition was played in exceedingly wet conditions at Muswell Hill Golf Club on Friday, 5th May. The winner, with an excellent total of 34 points considering the conditions, was Mr. David Webber, who was presented with the trophy by Mr. David Macdonald.

The competition is open to all staff and students of the Dental

Hospital and School and it is hoped that next year there will be more competitors, especially from the student body. However, although the entry this year was small in number, the competitors had an enjoyable day and all expressed their sincere thanks to Mr. Aidan Stewart for the excellent arrangements at Muswell Hill.

Sponsored Cross Channel Sail

The Sailing Club's noble attempt to sail across the Channel in dinghies over the May Bank Holiday was thwarted by bad weather. The Club who hope to raise money for the R.N.L.I. and for a new boat fund, will make another attempt in mid-July. Let us hope the weather improves for them—for if an American botanist can pedal his way to France, then surely Guy's can sail across.

Dates from the Medical Diary

July

Mon. 2 Basic Medical Sciences Examinations (6th term) begin.

Fri. 6 Entry forms for the Preliminary Examination for Studies in Medical Subjects (resit) must be left in the Medical School Office not later than this date.
SUMMER TERM ENDS.

Fri. 27 Schedules for the Final Conjoint Examination in September must be left in the Medical School Office not later than this date.

Dates from the Dental Diary

July

Mon. 2 Newland-Pedley Medal and Prize for Operative Dentistry—thesis must be handed into the Medical School Office not later than this date.

Mon. 2 Applicants for the Final L.D.S. Examination, Part II (Dental Prosthetics) (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Fri. 6 Entry forms for the Preliminary Examination for Studies in Medical Subjects (re-sit examination) (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.
SUMMER TERM ENDS

Mon. 9 Applications for the Final L.D.S. Examination, Parts I and III (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Obituary

FREDERICK AUBREY WALKER, F.D.S., R.C.S.

Fred Walker has recently died, aged 80. He was educated at Emanuel School, Wandsworth. In the latter part of the 1st World War he served with the Machine Gun Corps and was wounded in 1918.

In 1919 he entered Guy's Hospital, qualified in 1923 and was appointed House Surgeon and Demonstrator in the Prosthetic Department. On Kelsey Fry's elevation to the Senior Staff, Walker became Director of the Prosthetic Department and practised at Brixton.

In 1940 he joined the E.M.S. and worked at Rooksdown House, Park Prewett Hospital, Basingstoke in the Maxillo-Facial Unit with Sir Harold Gillies and with Professor Martin Rushton. He was the mainstay of the Oral and Dental Department of the Plastic and Jaw Injuries Unit throughout the 1939–45 War. Together with an engineer colleague, Mr. Clouston, he developed a unique type of pin fixation for jaw fractures which became known as the Clouston-Walker apparatus, which was invaluable in the pre-antibiotic days prior to 1944–45. He gained immense experience in the treatment of war casualties and was kind enough to contribute a chapter, with the late Patrick Clarkson, on Gun-Shot Wounds of the Face and Jaws in the textbook *Fractures of the Facial Skeleton* written by the late Professor H. C. Killey and Dr. N. L. Rowe and first published in 1955.

In 1948 he was elected to the Fellowship in Dental Surgery of the Royal College of Surgeons of England.

During the period 1948–59 (when Rooksdown House closed and transferred to Roehampton) Fred Walker combined his sessions at Basingstoke with sessions at Kingston General Hospital and also continued with his private practice in Harley Street, leading a very busy life involving a great deal of travelling. His interest in, and loyalty to, the Unit and his patients was outstanding.

After retirement from the N.H.S. he continued for a while in private practice and later moved to Hitchen where his daughter lived. He had the use of a stretch of river somewhere in Wiltshire where he could enjoy his favourite pastime of fly fishing—a pursuit shared, on many occasions, with Sir Harold Gillies who was an expert in this sport.

Fred fractured his skull two years ago, from which he really never recovered, though he tried to carry on his social work in the village. Two months ago he had a very severe stroke and died three weeks later. He was blessed with 52 years of devoted married life and our deep sympathy is with his wife, Kay, his son and daughter.

K.H., A.R.F.T., N.L.R.

ERNEST THOMAS CONYBEARE, C.B.E., B.Sc., M.D., F.R.C.P.

E. T. Conybeare died suddenly on 2nd April, 1979. The surname is not a common one, so it is all the more remarkable that Guy's could boast two notable physicians with this appellation contemporaneously, John Josiah (otherwise "Coney") and Ernest Thomas (otherwise "Con").

E. T. was born in Plymouth on 5th November, 1903. Leaving the College there he entered Guy's Hospital Medical School where, unusually during that era, he initially obtained the B.Sc. degree of the University of London with First-Class Honours in physiology in 1926. Two years later he qualified M.R.C.S., L.R.C.P., going on to achieve the M.B., B.S. (London) in 1930, the M.R.C.P. in 1931 and the M.D., with the particular distinction of the university gold medal, in 1938. The award of the F.R.C.P. followed in 1938.

Not that this impressive array of attainments within so few years derived simply from a devotion to passing examinations, for during this time E. T. managed to survive, with conspicuous success, the junior medical appointments at Guy's of assistant house surgeon, out-patient officer and house physician, before spending a year over 1931–32 as John D. Archbold fellow in medicine at the Johns Hoskins University. Resuming the rigours of clinical practice in Britain, E. T. served as a medical registrar at Guy's from 1932–36, at the same time being very active in the Journal Club.

Then it was that he took the bold decision to join the Ministry of Health, first in an epidemiological capacity and later concentrating on pharmacology and therapeutics, especially with the working of the Therapeutic Substances Act. In this role he published incisive papers on Hodgkin's disease, asthma, salmonella food poisoning, tetanus and acute rheumatism. Invaluable, too, was the survey he conducted on the incidence and severity of encephalitis consequent upon smallpox vaccination.

Despite the official nature of his appointment, which he retained until his retirement, E. T. never succumbed to bureaucracy, nor did he suffer bureaucrats gladly. With his own sound background in clinical medicine he was always able to present the medically independent point-of-view. Quiet and unostentatious he commanded an enormous and extensive fund of knowledge and his comments were always dispassionate and penetrating. His value in the Ministry went neither unnoticed, nor unacknowledged, and fittingly he became the recipient of the C.B.E. in 1964.

Eschewing, as ever, the narrow academic path, he was an energetic player of lawn tennis and club hockey, even until 1959. At Guy's he was producer of the Residents' Plays of 1929, 30 and 31 and for many years thereafter he was an enthusiastic performer in Gilbert and Sullivan operettas.

Always close at heart to Guy's, the alliance was further forged maritally, for in 1938 he married Marjorie Deacon Blaikley, the sister of John Blaikley, obstetrician, gynaecologist and Superintendent of the Hospital from 1958 to 1966. Of the two sons and two daughters of the marriage, one son is a surgeon who also qualified at Guy's.

Physically, E. T.'s later years were marred by the disabilities of rheumatoid arthritis, which he bore with customary stoicism. It is difficult to believe that he is gone, for even if one did not see him frequently, one always accepted that he was there, unassumingly in the background, ready with sensible guidance and subtle humour whenever he was approached.

R.G.

Clubs' Union News

Summer General Meeting

The summer general meeting was not held on Thursday the Fourteenth of June because only fifty people could be bothered to turn up. Apathy on this scale seriously damages the creditability and morale of all the officers who are responsible for your internal and external representation as well as the diverse services provided by the Clubs' Union. A general meeting is a body which supposedly determines the policy pursued by the Council. If it is not possible to appreciate what the collective thoughts of Guy's students are, as opposed to the views of the small and probably a typical population who write letters in the student press or even actually come and talk to us about issues of importance, your representation will more likely than not be out of touch as well as being all but unaccountable.

At the meeting of the sub committee set up to consider Lord Annan's letter recommending the closure of the preliminary year I vainly made my usual arguments about educational and moral principles with regard to the narrow criteria that future medical and dental applicants will have to satisfy. In the light of the proposal from the Academic Advisory Board of the University of London who suggested that the course be retained at either Guy's or Bart's I felt there was some chance that Guy's would be anxious to prove their course was better than the one offered at Bart's. This did not prove to be the case. The argument for retaining the course at both schools has I think been weakened enormously by the fact that the number of entrants for next year at Guy's will be less than 15. In an economic climate that next year may well see the Flowers committee recommending the closure of one of London's medical schools, to run a course for less than 15 students is difficult to justify. However, the decision to recommend closure of the Guy's course to the University (which still needs ratification by the Council of Governors) was taken by a very few people. The majority in the sub-committee was only three; the same number as the narrow majority at the School Council meeting which approved this sub-committee's recommendation. A major consideration for the School is that by closing the course this will release lecturers from teaching commitments and so save money because the inevitable expansion of academic departments will be in part met from the lecture time saved. So although there will be no immediate savings, by a shift to more efficient teaching of students it was argued that the taking on of more staff can be delayed.

As far as student interest at Guy's is concerned, this is the end of our influence. However, the U.L.U. medical group have prepared a long reply to Lord Annan's letter which says in effect that whatever a school will save, the University as a whole will probably save nothing in the short term and very little in the long term. Despite this long shot I think the emphasis for us now ought to change towards ensuring that both the University and Guy's do honour their belief that graduates in particular have a valuable contribution to make, with some concrete financial assistance for graduate applicants.

Freshers' Handbook

We are at the moment finalising the copy for inclusion in the 1979 Freshers' Handbook. It is intended to carry on the style of the excellent publication that first appeared last year but with a bit more emphasis on living in London and S.E.1 in particular. I hope this short note will act as a reminder for all the Clubs secretaries to return their written exhortations to the Freshers as soon as possible.

Chas Newstead.

Summer Festival 1979

This event was held on the second of June at Honor Oak Park. By an extraordinary piece of good fortune we chose THE Saturday this summer during which the sun shone. This, coupled to extensive advertising, resulted in a gate of about 700 people who managed to consume throughout the day something like the equivalent of 3,250 pints of beer. During the afternoon twenty male and eight female five-a-side teams fought for the football club prizes. The tennis club held their popular mixed doubles tournament. Fourteen teams of six players manfully pitted their wits and skill and sense of dignity in a series of games that involved them at various times in throwing eggs at each other, scrambling along a greasy flagpole and playing volleyball against our star team from New Cross. Late afternoon saw the awe-inspiring efforts of the Rugby Club who re-established their traditional mastery in the Tug-of-War.

In the evening that portion of the crowd who had stayed the course were entertained in the marquee by a professional disco and a band. Though we set the entrance fee and drinks prices as low as was possible consistent with not making a loss we did in fact manage to make a small surplus of about £120. It had been decided beforehand to donate any proceeds to THE FRIENDS OF GUYS. This will be done as soon as the precise figures are calculated.

We would like to record our thanks to Eric Dann and his staff at H.O.P., as well as all those students who worked so hard on the day as marshals, gate guardians, bar staff, compères, raffle-ticket sellers and so on; and also those who laboured for days before hand organising sound systems, beer management, ground layout, all-night security and transport, as well as procuring the multitude of things needed to make the day the considerable success that it was.

Chas Newstead, Simon Cunnington.

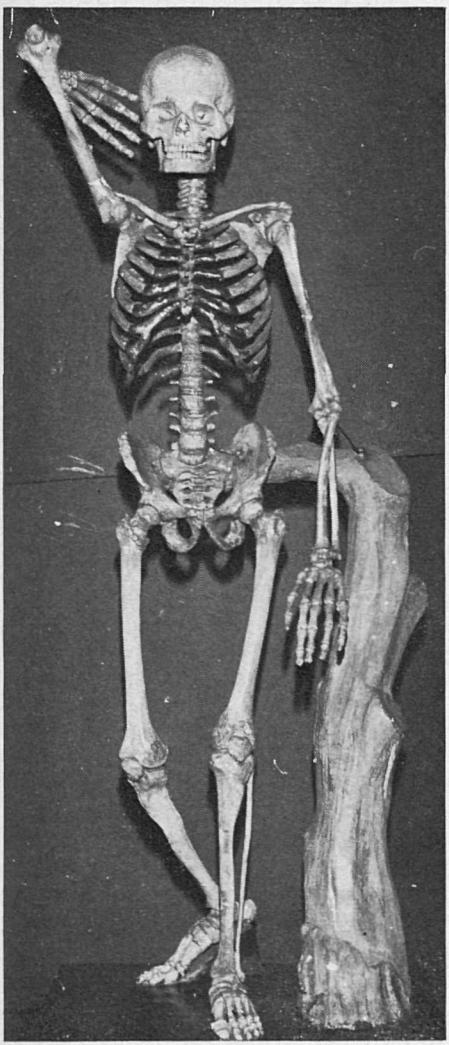
The Remarkable Joseph Towne 1806-1879

by J. Daws, Gordon Museum

One hundred years ago on the 25th June 1879 Joseph Towne died. He had held the post of modeller to Guy's Hospital for 53 years and although outside of Guy's his name is probably unknown, he was without doubt a most prolific and skilled artist. He is also unique in that all his models were produced here and with few exceptions are retained in the Museum as a single collection.

Early History

He was born on the 26th November 1806 in the town of Royston in what was then the county of Cambridgeshire. His father, the Rev. Thomas Towne, a dissenting minister, was himself no mean artist, having exhibited paintings at the Royal Academy and published articles on the art of painting on velvet and on the *camera obscura*. Joseph Towne was one of five surviving sons of which one, Elihu, had later associations with Guy's. We have very little information regarding Towne's early



Joseph Towne's original model of the human skeleton which gained the admiration of Sir Astley Cooper.

upbringing, although it can be surmised that any artistic ability that he possessed would have been encouraged by his father. Thomas Bryant in his *In Memoriam* to Joseph Towne, does however record the story of how one night the father on being disturbed by a noise, found the young Joseph engaged on the construction of his first model, that of the small skeleton (above) that we still possess in the Museum. The father then

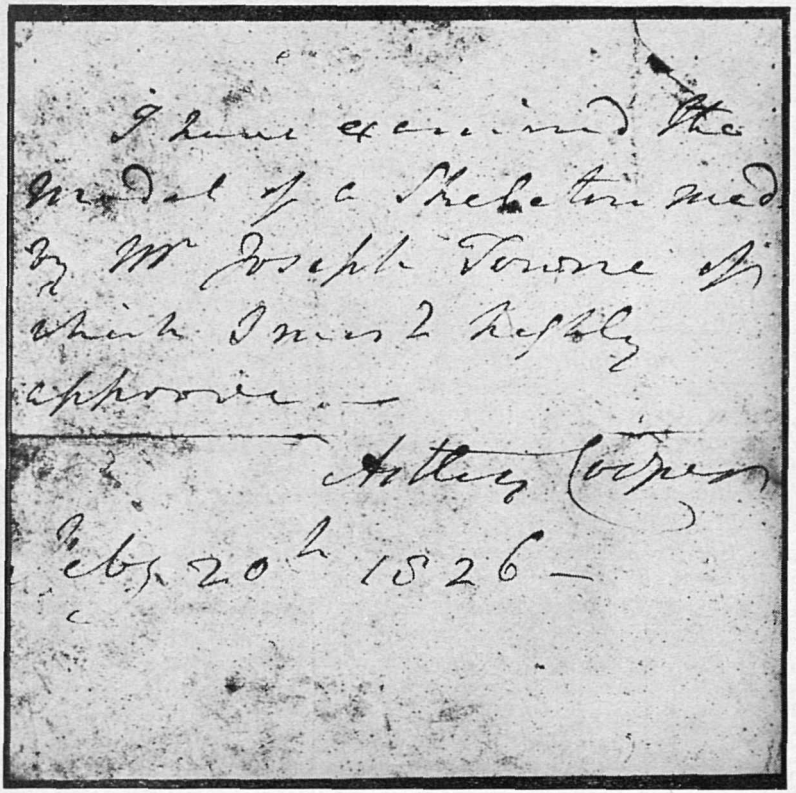
suggested that Towne should go to the Fitzwilliam Museum at Cambridge, meet a Professor Clarke, and compare his skeleton with one exhibited there. Certainly this connection with Professor Clarke was most important, as records show that he was engaged in the building up of the teaching collection in the Anatomy School and was in fact already purchasing wax anatomical models from Florence, there being none available in England. With Thomas Towne's connection with the world of art and Professor Clarke's interest in anatomical models they would both, I am sure, have been aware that in that year of 1826 the Royal Society of Arts was offering a gold and silver medal for the best wax anatomical model submitted to them. In any event, armed with this beautiful example of a miniaturised human skeleton in wax the young Joseph Towne, now aged 19, proceeded to London.

Appointment at Guy's

Before submitting this model to the Royal Society of Arts, Towne quite sensibly decided to get its accuracy authenticated and so visited a number of medical practitioners from whom he received the glowing testimonials that we still possess. On February 17th he visited Dr. Thomas Davies and Dr. R. C. Headington, and on 18th February he visited Richard Granger, Lecturer in Anatomy and Physiology at Guy's. It is interesting to note that Granger then ran the private School of Anatomy in Webb Street founded by his brother Edward; and Alexander Towne, a cousin of Joseph's, received his training there before gaining his M.R.C.S. on April 7th, 1826. This may be the answer to why this young man undertook what must have been quite a hazardous journey to London ending up in the vicinity of Guy's Hospital. It is certain, however, that Granger sent Towne to see Mr., later Sir, Astley Cooper, Senior Surgeon at Guy's, whose framed testimonial is exhibited alongside the skeleton in the Museum, and reads as follows: *"I have examined the model of the skeleton made by Mr. Joseph Towne of which I approve —Astley Cooper—February 20th, 1826."* He also gave the young Towne a letter of introduction to Benjamin Harrison, Treasurer of Guy's, and so began the appointment of wax modeller to Guy's Hospital at the opportune time when Guy's had just formed its own Medical School, an appointment that was to last for the next 53 years. His future now secure, Towne submitted the model of the skeleton to the Royal Society of Arts and received the silver medal, and the following year submitted models of the brain for which he received a gold medal. Richard Granger wrote *"The models are accurate copies of different parts of the human brain they are intended to represent. They are among the very first attempts which have been made in this country to represent the different parts of the human body by wax models"*. With reference to the same models John Morgan wrote, *"I have examined three wax models of the human brain which have been recently made by Mr. J. Towne. They are by far the most beautiful specimens of the kind that I have ever seen and all minutely correct as regards their representation of the exact appearance which that organ presents upon dissection"*.

Modeller to Guy's Hospital

At this time the demonstrator of anatomy was John Hilton, an outstanding dissector, later to achieve fame when he delivered a memorable course of lectures which were afterwards published as the classic *Rest*



The testimonial from Sir Astley Cooper.

and Pain. In collaboration, Towne produced, from Hilton's dissections, the superb collection of wax anatomical models that we still possess. Also at Guy's at this time was Thomas Addison who initiated the permanent recording of dermatological conditions by sending and encouraging others to send patients to be modelled by Towne, so endowing us with the enormous collection of models. The speed at which Towne worked is unknown, but some indication is shown by the large number of models already completed and listed in *Hodgkins Catalogue of the Museum* published in 1829. Hobershon's *Catalogue of the Models of Diseases of the Skin* published in 1854 lists three hundred models, and by 1876 Fagge's addition of the same catalogue lists five hundred and thirty seven models.

The Man at work

Few records exist of the actual conditions and method of paying Towne when he was first appointed, although it has always been stated that his most important requirement was that he be given a room of which he would have the only key. Such a room listed as "The Modelling Room" is indicated on the ground plan of *Guy's Hospital and its Medical School in 1835* shown in Cameron's *Mr. Guy's Hospital.* Bryant stated that up until 1853 Towne's salary was paid partly by the hospital and

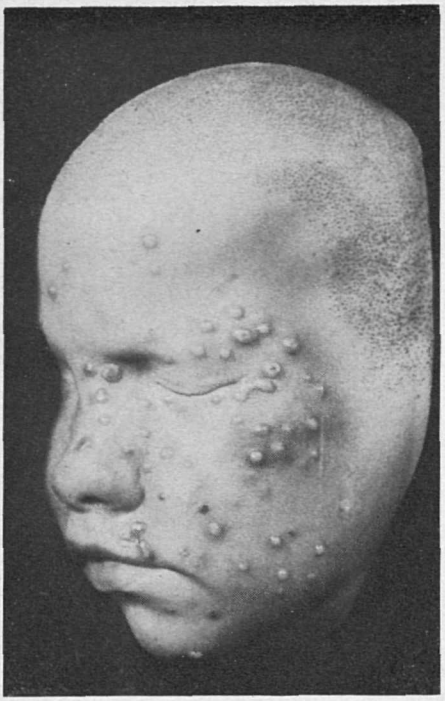
partly by the school, and from that date the school paid all the salary. In the Minutes of the Court of Committees held on the 7th June, 1843, it was resolved that a salary of £200 a year be paid to the Modeller. I think, however, that this sum must have been some sort of retainer, as in a letter of 1872 from the then Treasurer, Thomas Turner, he mentions remuneration for a specific model. One of the most interesting descriptions of Towne was given by Frederick Griffith who, when describing a visit that he made to Guy's, spoke to a person called "Mills" the old doorkeeper at the Nurses House who stated that: *"Oh yes, I knew Mr. Towne. I was a young man and, being bright and active, he sent me errands. There's no one left about here that knows him, except me. He was a strange man, was Mr. Towne. He worked in the basement over there under what is now the eye ward. Mr. Towne never liked to have anybody around when he worked and none of us ever saw him at it. Being forward then, I used sometimes to try and find out how he did it. But he would never let me get close enough to see anything before he would stop work and come over to me and say, 'Well, do you want anything', Mr. Towne always wore a cloth over his head when he was putting on his colours. Oh, Mr. Towne was mortal afraid of dust. 'Don't make a dust, Mills', I can hear him say over and over. Besides me and Francis, the Italian plaster-mixer, Mr. Towne had for an assistant one William Bouch, who was used as a model. Mr. Towne was a silent man."* Mills continued in the same strain: *"Mr. Towne was rather heavy set, not very tall, with sparse, gray hair. He never ate much. A sandwich and a mug of beer lasted him all day. He didn't have many instruments and they looked like masons' tools, and he used to mix the wax in a pewter bowl."*

As previously mentioned, records show that up until about 1838 Elihu, Towne's younger brother, was resident in Maze Pond, and his profession was shown as Anatomical Modeller. A letter that we possess sent in 1831 by Sir Astley Cooper praises the progress that Elihu was making in his modelling career. Elihu left Guy's soon after this period and died en route to Abuzabol, a small village on the outskirts of Cairo. It was here that a medical college was being built by Muhammed Ali under the direction of Clot-Bey, a French surgeon who visited Guy's in 1833, and was very impressed with the wax collection.

Technique

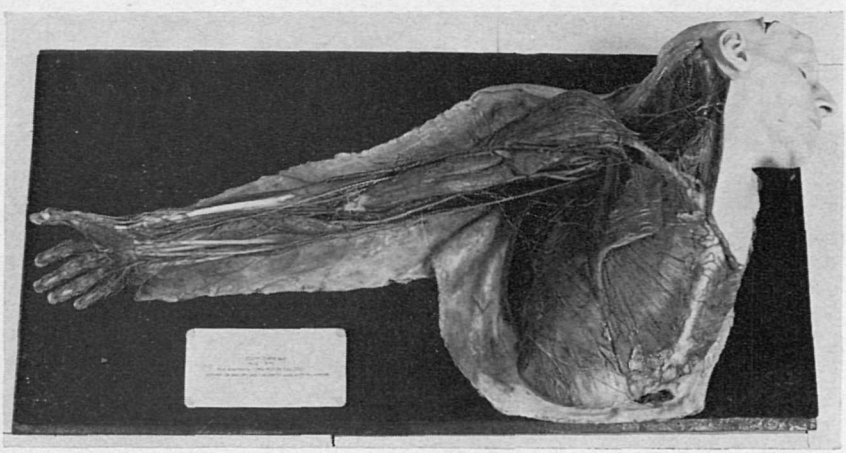
The rather simple instruments used by Towne have been preserved in the Museum, and basically consist of a light gouge or chisel, some spatulas in wood and bone and a dull knife. In a recent analysis of samples of wax carried out by Dr Raymond White of the National Gallery he found that those samples taken from the anatomical models were a mixture of bees wax and spermaceti wax and that from a dermatological model was pure beeswax. X-rays taken of the anatomical models show no complicated armature as would be expected if the models had been cast, while those of the skin models show a basic wooden structure that would suggest that these had been cast. It is very recently that a conservator, concerned primarily with artistic waxes, immediately observed that two skin models illustrating entirely different conditions had identical faces. So it could be supposed from what little evidence that we now possess that Towne sculptured the anatomical models but had a very large number of casts on which to illustrate the skin diseases.

Incomparably Towne—his wax anatomical model of the head and neck.



Left, an example of Towne's dermatological models—Varicella.

Below, a dissection of the chest, neck and arm.



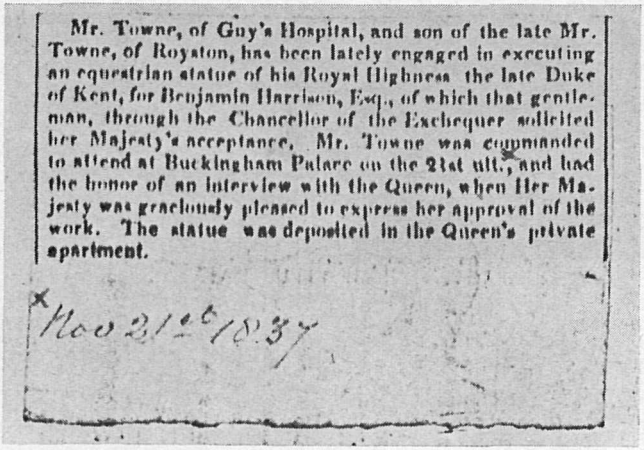
Fame

It is obvious that Towne's remarkable talent could not be confined solely to Guy's. One has only to glance through the Museum visitors books of the period to note thousands of names of eminent people from all over the world who would have seen this remarkable collection. In 1851 Towne exhibited wax models at the Great Exhibition in Hyde Park and again in 1855 at the Paris Exhibition. Bryant states that fine speci-

mens of his work are seen at Calcutta, Madras, Bombay, New York, New South Wales, Russia and Alabama. So far these examples have not been located. However, Haviland (1970) describes models made by Towne still contained in the Louis A. Duhring collection in the Department of Dermatology at the University of Pennsylvania. There is also a small collection of twenty-one anatomical models in the Anatomy School at Cambridge. These were given after Towne's death, so re-establishing his early contact with the School.

Non medical waxes

Being primarily an artist, Towne did not confine his wax modelling entirely to medicine. In 1837 he made an equestrian statue of Queen Victoria's father the Duke of Kent, and although the newspaper report


Mr. Towne, of Guy's Hospital, and son of the late Mr. Towne, of Royston, has been lately engaged in executing an equestrian statue of his Royal Highness the late Duke of Kent, for Benjamin Harrison, Esq., of which that gentleman, through the Chancellor of the Exchequer solicited her Majesty's acceptance. Mr. Towne was commanded to attend at Buckingham Palace on the 21st ult., and had the honor of an interview with the Queen, when Her Majesty was graciously pleased to express her approval of the work. The statue was deposited in the Queen's private apartment.

Nov 21st 1837

Newspaper Item re. Model of the Duke of Kent.

does not specify that this was in wax, it seems highly probable. Unfortunately this piece has not been traced so far. One of Towne's most beautiful waxes, exhibited in the Museum, is a copy of the Bacon Monument to Thomas Guy in the Chapel (overpage). This, or a copy, was reported by Eason in the *Gazette* of 1936 as being part of the collection of Sir Frederick Cripps of Cirencester. It should be pointed out that Benjamin Harrison's sister had married into the Cripps' family. We also possess a wax of John Guy, brother of Thomas, from the same collection. One of the waxes of great interest is a sketch model of the Duke of Wellington, who had been leader of Parliament when the Anatomy Act was first presented. This model had been almost certainly used for the marble statue of the Duke exhibited at the Royal Academy in 1835.

Sculptures

It has already been stated that Towne almost certainly sculptured his wax anatomical models, and so then to work in marble does not seem such a great change. This material however needs different skills, some

A wax copy of the Bacon Monument to Thomas Guy in the Chapel.

Sculptures of Richard Bright and Thomas Addison.

of which would have to be learnt. Bryant mentions that the possibility had been considered for Towne to be a pupil of Behnes and certainly there were family associations with this distinguished sculptor. In any event, the number of pieces produced by Towne was enormous. The list shown of those pieces exhibited at the Royal Academy is fairly extensive, but many others were made. In the front hall of the Medical School there are marble busts of Addison and Babbington, and a plaster of Richard Bright. The most impressive piece is that of Towne's mentor, Sir Astley Cooper, raised to his memory by his pupils in 1842. The Royal Acadamician, Bailey, then concerned with his own statue, eventually to be placed in St. Paul's Cathedral, was so impressed by this that he asked if he could have a cast from Towne's bust in order to correct the head of his statue. A bust made by Towne in 1850 of Florence Nightingale is exhibited in the Russel Cotes Art Gallery in Bournemouth having been made long before her Scutari fame. In the catalogue of the Sale of Sir Frederick Cripps collection in 1959 are listed two marble busts by Towne and dated 1834 and 1840 and it could be hoped that, due to the family connection, the first is that shown in the Royal Academy list as of Benjamin Harrison. This has not been traced and it is particularly unfortunate in that the only "picture" we have of Harrison is the etching from the Wellcome collection shown in Cameron's *History of* Guy's. There is, however, the monument to Benjamin Harrison with a

The unknown Lady from Repton School.

plaque, erected in St. Mary's Church, Balham. Busts of Nelson and Wellington and one of Bishop Otter in Chichester Cathedral have been traced, but almost certainly there are many pieces in existence, and in private hands, of which we have no knowledge. A recent acquisition by the Medical School is that bust of the lady made by Towne in 1856 which stood for many years in the library at Repton School. It has so far not been identified.

Publications

In 1839 Towne turned his attention to the subject of the incubation of the egg, and on a suggestion of Harrison prepared a series of models showing the changes that take place. These models also shown at the 1851 exhibition cannot be traced, but drawings of them by Canton and Towne's observations were published in *Guy's Hospital Reports* of that year. Towne delivered a series of lectures on the brain and on the organs of the senses and intellect, and these were expanded into a series of papers began in the reports of 1862 and ending with a paper on binocular vision in the volume of 1870.

Joseph Towne died on 25th June 1879 at Sefton House, Eltham, and he was buried in West Norwood cemetery. In his Will he left all his casts to Guy's and his collection remains a permanent memorial to a remarkable man. He was in fact the first and also the last English anatomical wax modeller, but although the need for wax anatomical models became less important after the passing of the Anatomy Act in 1832, when pathological lesions could be easily preserved as wet museum specimens, and skin lesions recorded by colour photography, these models still have their place in the teaching and history of medicine.

Acknowledgement

Throughout the 1960s we were fortunate in having contact with Rupert Towne, great-great grandson of Joseph and the last remaining male heir. He was intensely interested in his famous ancestor, and when he died his wife kindly handed over all the information that he had obtained. It is from his industrious research that much of the information for this article was obtained.

After Towne - Anatomical modelling at Guy's Today

by Dr. M. C. E. Hutchinson, Anatomy Department

Introduction—Early Techniques

For hundreds of years Anatomists have been preparing anatomical specimens for the purposes either of teaching or research. Leonardo da Vinci (1452–1519) made models of the cerebral ventricles using wax. Wax was subsequently used extensively as an injection material to fill blood vessels and cavities such as the gall bladder and the uterus. Towards the end of the seventeenth century various metals were used as an injection medium. Very low melting point metals were devised, culminating in Woods metal which melts at about 70°C. Such metals were used to investigate the bronchial tree and were still being used until the last war. Lord Brock's work on the surgical anatomy of the lungs included the use of Woods metal, one such cast is to be seen in the Gordon Museum. Mercury was used, notably by Mascagni (1752–1815) to show the lymphatics of the body. Added to this, carefully prepared dissections could be preserved in alcohol and mounted in glass jars.

Furthermore, wax models, notably those of Towne, were made to simulate the real thing. This technique was used extensively on the continent, particularly to demonstrate various stages in embryology. A collection of these can be seen in the Anatomy Department at Guy's. It is not the intention of this article to go into the history of anatomical modelling, but suffice to say that all the techniques so far described have serious drawbacks. Wax is very fragile and metal is far too heavy, distorting the tissues.

Plastic Techniques

After the second world war the use of various plastics was introduced. This was largely pioneered in England by Tompsett at the Royal College of Surgeons. Over the last few years, in the Anatomy Department at Guy's we have been using this technique and a number of others to build a museum. So far this occupies a small section on the ground floor of the Gordon Museum near the Towne models.

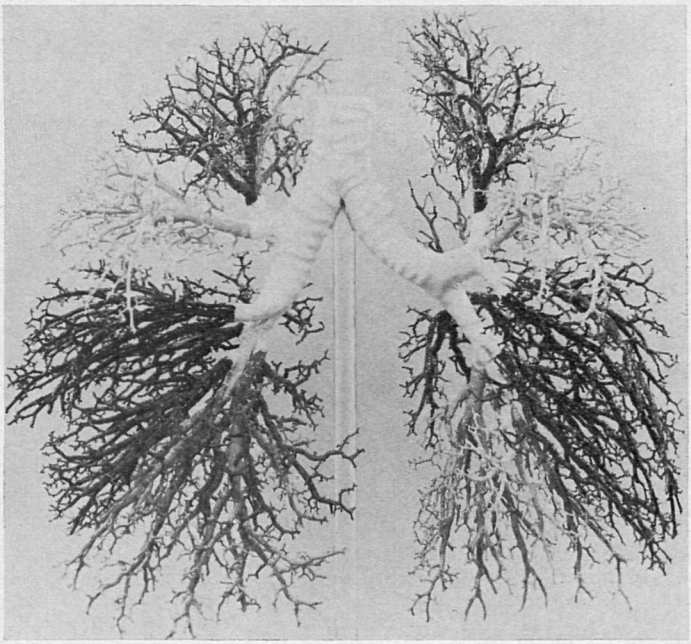


FIGURE 1

A resin cast of a human bronchial tree, pruned to show the segmental bronchi and their major divisions. Note the impressions left by the cartilogenous rings in the trachea and main bronchi.

Resin Casting

Resin casting can be applied to many different organs but lungs lend themselves particularly well to this technique *(see fig. 1)*. The resin used is an unsaturated polyester resin, very similar to the resin used in fibre glass construction. The resin is a clear syrupy liquid, the viscosity of which can be altered according to the needs of the particular injection. Colour pigments can be added to the resin if desired. The resin is made

to set by the addition of a catalyst. An exothermic chemical reaction ensues once the catalyst has been added. The amount of catalyst and the starting temperature are critical to the length of time available before the resin sets. It is during this stage that the injection must be completed usually between 4 and 10 minutes. In the case of lungs a preparation can be made of the bronchial tree, the pulmonary arteries or pulmonary veins in any combination *(fig. 2)*. The following is a brief description of the procedures taken to obtain a specimen such as a bronchial tree *(fig. 1)*.

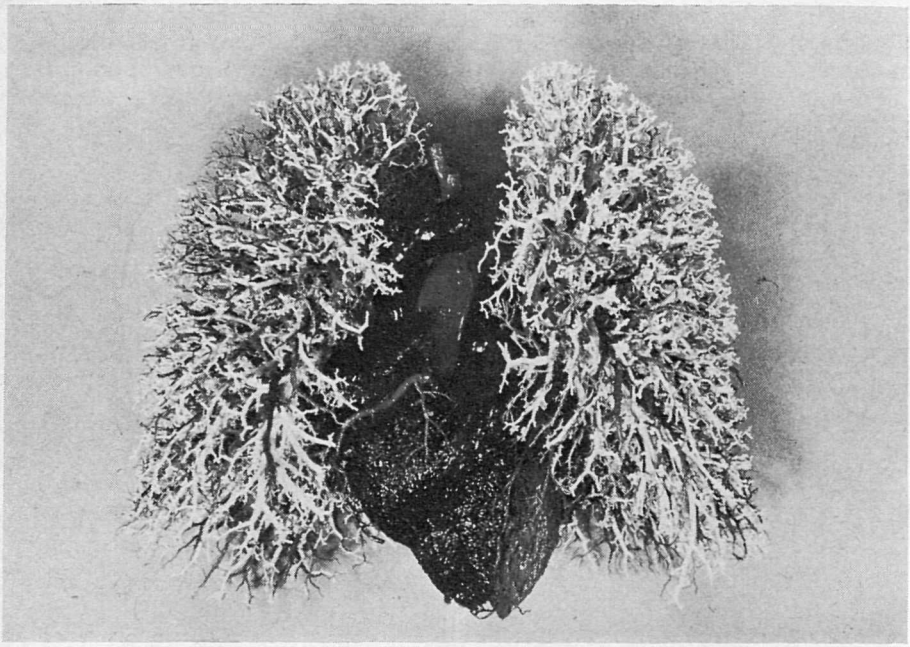


FIGURE 2

A triple injection of the bronchial tree, pulmonary arterial and venous trees and the heart. A specimen such as this may take a week of painstaking pruning to remove the unwanted small branches.

A completely intact pair of fresh lungs is required. The trachea is cannulated and dilute formalin is perfused through the lungs. This serves the purpose of both fixing the lungs and expanding them into their original shape, which is a considerable problem with this particular organ. A standard amount of resin is prepared by adding the required pigment and catalyst. The resin is then poured down the cannula into the bronchial tree. Very little pressure is required; gravity is usually quite sufficient to push the resin almost as far the alveoli. If pressure is required for any reason—for instance the injection of arterial systems such as the hepatic or coronary arteries—then air pressure can be applied via a Higginson syringe on top of the column of resin. Once the

resin has set it is allowed to cure for several days. Then the whole lung is immersed in concentrated hydrochloric acid. This corrodes away the soft tissues in about 2 days, leaving behind the resin cast. A great deal of work then has to be done to prune away the unwanted detail. Figure 1 shows the bronchial tree, pruned and painted in different colours to represent the segmental bronchi (The original of this specimen can be seen in the Gordon Museum). The same technique can be applied to produce casts of the liver, kidney, placenta, heart and brain.

The advantages that these modern resins have over the older techniques are several. They are cheap and very light and at the same time reasonably strong. They also neither expand nor contract during the curing process. The viscosity is just about right in that the resin will reach but not pass through the capillary bed. The models obtained are thus a faithful copy of the original.

Another major advantage is that the resin is cold when it is injected, unlike wax or metal which have to be heated up to a point which can damage the tissues. *Figures 1–7* give some idea of the various uses to which resin casts can be put.

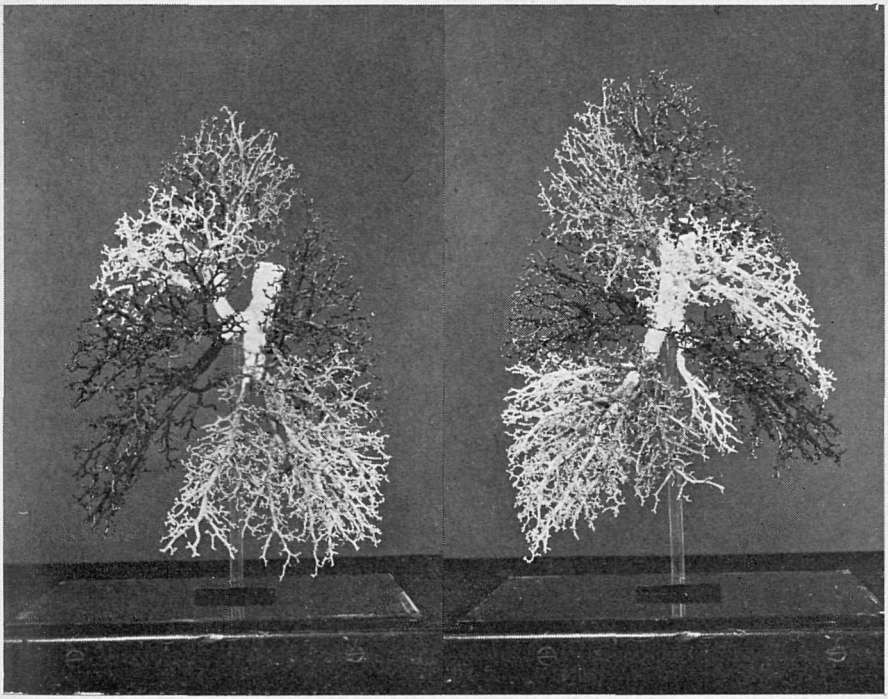


FIGURE 3

The lateral views of the bronchial tree of the right and left lungs separated.

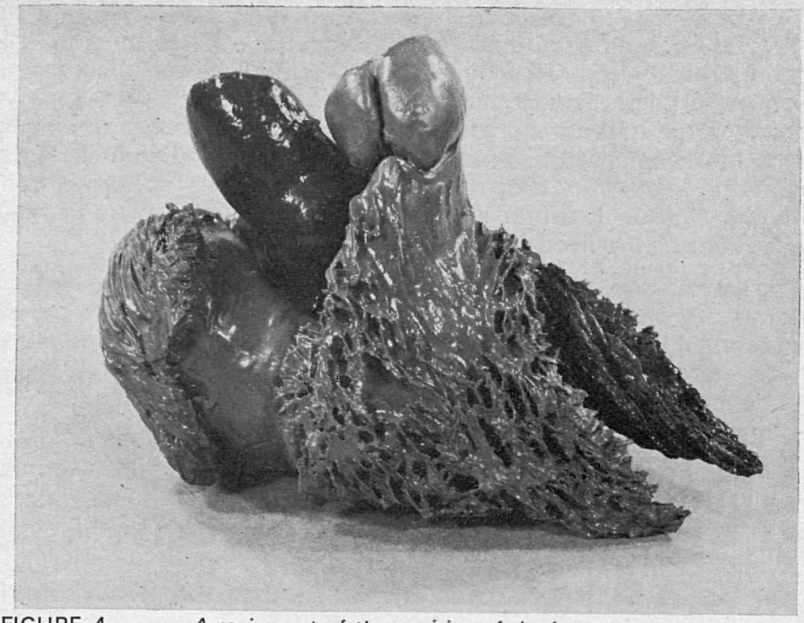


FIGURE 4 *A resin cast of the cavities of the heart.*

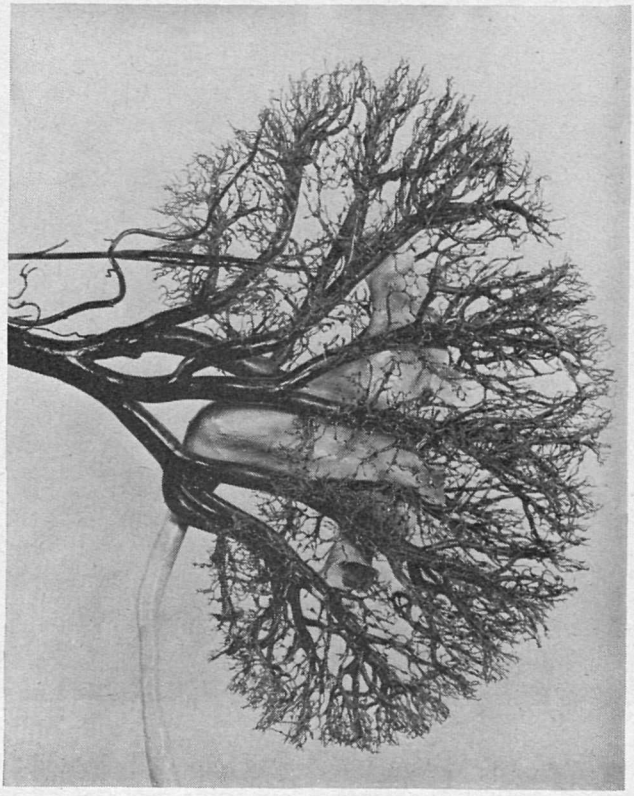


FIGURE 5 *A resin cast of the renal artery and pelvicalyceal system of the left kidney.*

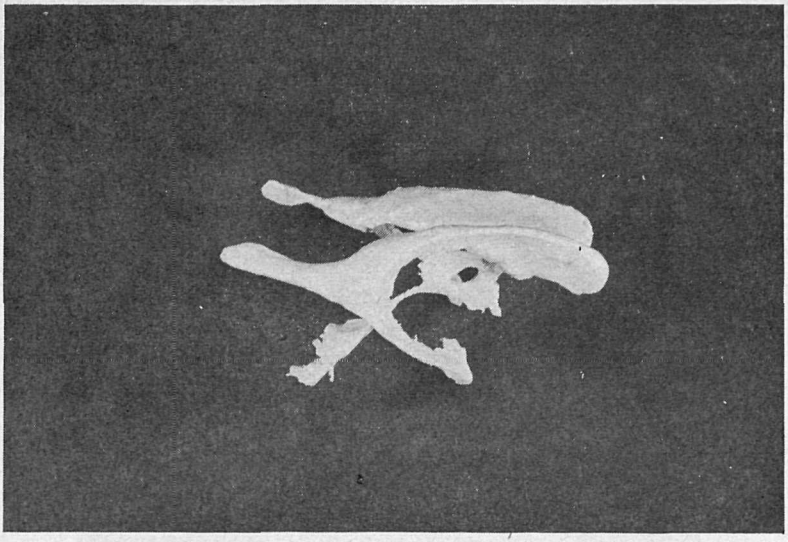


FIGURE 6

A resin cast of the cerebral ventricles.

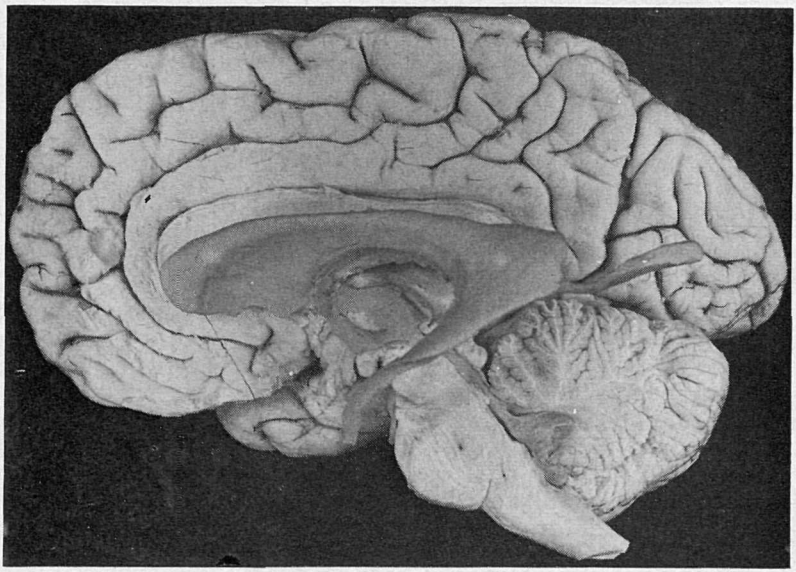


FIGURE 7

A hemisection of the brain with the ventricles in situ. Injection of the ventricles is not as simple as it might seem. A cannula is pushed into each lateral ventricle from above. Resin is then poured in under gravity. There are two main problems. One is the considerable leakage from the region of the 4th ventricle and the choroid plexus. The second is the difficulty of persuading the resin to go into all the recesses of the lateral ventricles, air locks occur particularly in the posterior horns. Once the resin has set the brain can be dissected away rather than corroded.

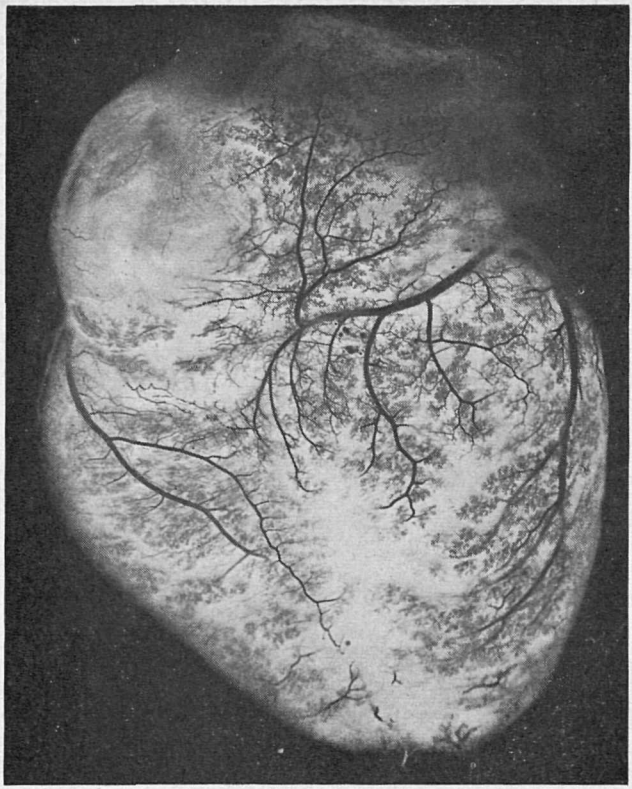


FIGURE 8

The diaphragmatic surface of the heart with the coronary arteries injected and cleared. This is a negative image. The photograph is taken with the heart fully immersed in methyl salicylate.

Gelatin Injection Techniques

Another completely different technique can be used to show blood vessels. This involves injecting the required system with coloured gelatin. The gelatin has to be thick in order to prevent it going through the capillary bed. When the injection is finished the specimen is fixed in formalin, then completely dehydrated in alcohol. Finally it is rendered almost transparent in methyl salicylate. One major advantage is that the surrounding tissues are preserved thus supporting long, slender blood vessels that are all too easily broken from a resin cast. However, once the specimen is prepared it more or less has to stay immersed in methyl salicylate *(Fig. 8)*. This fluid is unfortunately a solvent of a number of plastics, so that the conventional museum pot cannot be used. There is one way round this problem, and that is to replace the methyl salicylate with clear resin and then cure the specimen into the middle of a solid block of clear resin *(Fig. 9 and 10)*. This technique is fraught with all kinds of problems. However, we have succeeded in putting specimens as big as a human heart into clear resin with only one lamination. The main problem is to dissipate the considerable amount of heat produced during the curing process. Small specimens can easily be embedded in resin. This technique is particularly useful for small bones such as the ear ossicles.

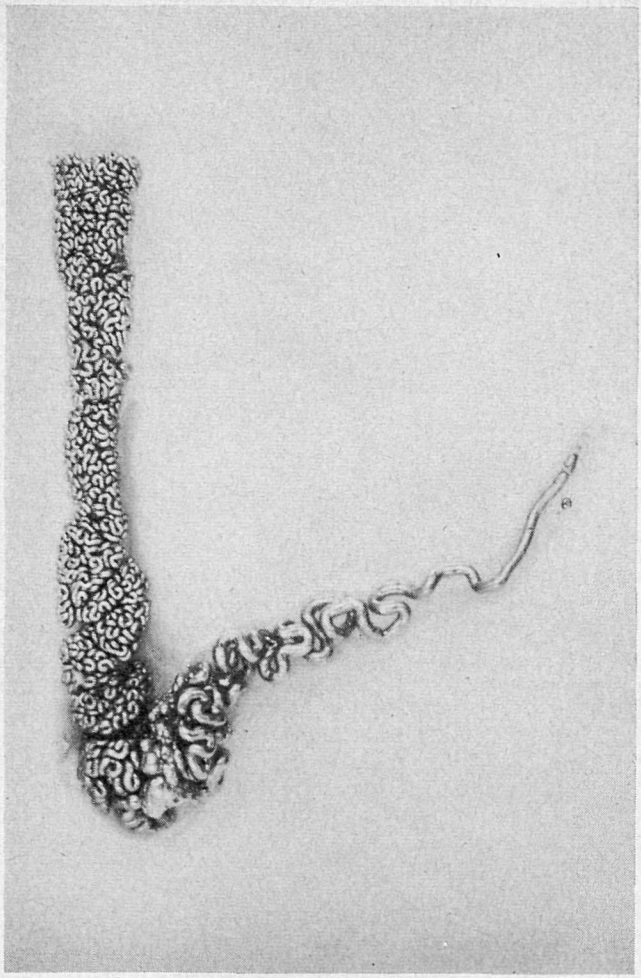


FIGURE 9

Mercury has been injected into the epididymis and the whole specimen cleared and embedded in resin.

Another dramatic way to demonstrate the segments of the lung is to inject coloured gelatin into the individual segmental bronchi. These bronchi can easily be identified in the hilum of the lung and each have a cannula tied into it. Then different colours suspended in gelatin can be injected in turn. The colours appear at the surface of the lung and the line of demarcation between one segment and its neighbour show very clearly *(Fig. 11)*. There is only a minimum of mixing at the boundaries.

Dissecting Techniques

It would be a pity to neglect the more straightforward dissecting techniques. For the purposes of a museum or any other kind of per-

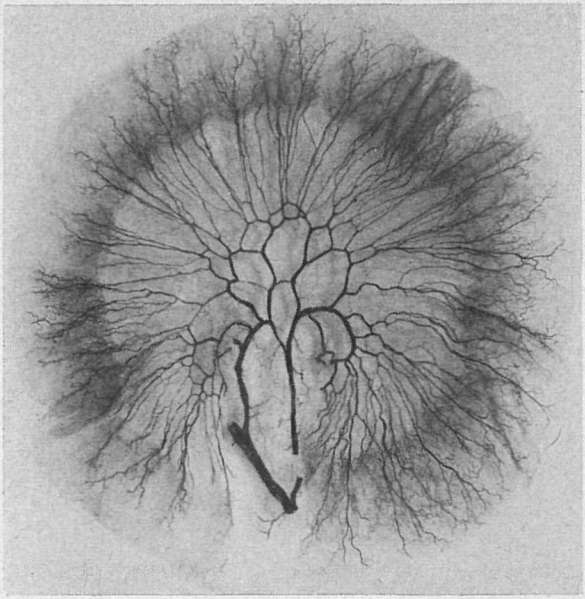


FIGURE 10

A coil of small bowel with its arteries injected and cleared. This specimen has also been solid-embedded in clear resin, which enables it to be handled easily.

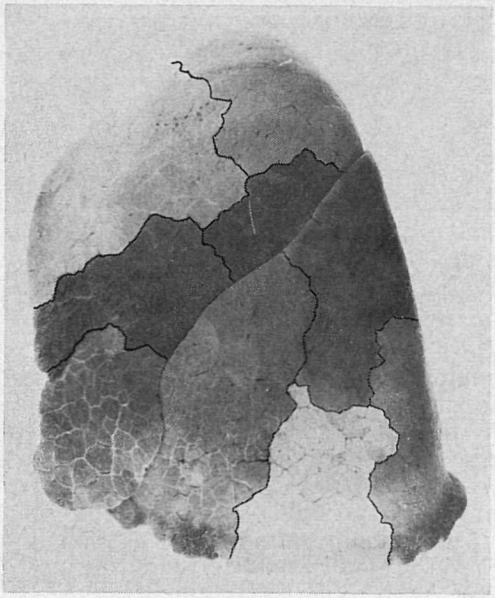


FIGURE 11

The left lung viewed from the costal surface showing individual segments. (Original is in the Gordon Museum.)

FIGURE 12

The bones of a 16-week-old foetus have been stained and then cleared in methyl salicylate. The specimen is first macerated in 2% potassium hydroxide for about one week, over-maceration will cause the specimen to fall to pieces. It is then transferred to a dilute solution of alizarin S (madder). This is taken up selectively by bone. The specimen is finally dehydrated and then cleared in methyl salicylate.

manent display the required dissection must be very carefully prepared, this may take many days. It is possible to inject the blood vessels with coloured resin or gelatin initially in order to highlight them. I have found that this is not always very satisfactory, and of course could not be done for nerves. In order to make blood vessels and nerves stand out more obviously it is possible to paint them with water soluble paints. Great care is necessary to prevent the colours from running onto the surrounding tissues. The colours can then be fixed in place with gelatin. Then the whole specimen is covered in gelatin. This is an essential step

as no matter how carefully the dissection is done fine strands of fibrous tissue remain, giving the whole specimen a "furry" appearance. The gelatin holds these down, effectively making them disappear. The specimen is then mounted in a perspex museum jar and immersed in a solution of formalin and glycerin. These museum jars are a great improvement

FIGURE 13

A dissection of the hand showing the deep part of the ulna nerve. Some of the small muscles of the hand can also be seen.

over the original glass ones which, in order to allow for expansion, had to have a bubble of air left behind inside. We make our own perspex jars—the joints are made using chloroform to weld the various pieces together. A completely watertight and "glass clear" joint can be obtained.

Museum specimens of this sort do have disadvantages. It is very difficult to point to a particular structure clearly, but accompanying photograph gets round this problem to some extent. The specimens can also be very heavy. However they are useful particularly to show the

FIGURE 14

A dissection of the sole of the foot to show the second layer of muscles and the arteries and nerves.

course of nerves and blood vessels, and it is hoped to add many more to the collection in the museum.

Acknowledgements. The illustrations were produced by Mr. Kevin Fitzpatrick, except Figure 7 which was taken by Mr. Tim Fisher.

Anatomy without tears (or the dissecting room then and now)

by Dr. M. C. E. Hutchinson, Anatomy Department

Every student who has passed through medical school will have vivid memories of the dissecting room. There is no doubt that on occasion the atmosphere can and does literally bring tears to one's eyes. But I wonder if we realise just how lucky we are in a reasonably modern dissecting room.

Cast your mind back to the beginning of the last century . . . "South, in 1813 had begun to dissect in the old dissecting room at St. Thomas's which had long been inadequate for its purpose. It was almost filled by twelve tables with *"their corresponding burdens"* round each of which *"Six or eight pupils crowded, clad in filthy linen or stuff dissecting gowns so that movement was almost impossible"*. According to Golding the impurity of the air was so great *"that many pupils were obliged to neglect that most essential part of professional instruction, practical dissection, lest they should thereby endanger their health, and perhaps their existence". This contemporary report is from Mr. Guy's Hospital.*

We ought perhaps to look more closely at the set up for teaching anatomy prior to the Anatomy Act of 1832. From the sixteenth century until the early part of the eighteenth century the Barber Surgeons had the exclusive right to teach anatomy, and this the Company jealously guarded. By an Act passed by Henry VIII the Company of Barber Surgeons was given the right to dissect executed criminals. The Act reads as follows: *"And further be it enacted by thauctoritie aforesayd, that the sayd maysters or governours of the mistery and comminaltie of barbours and surgeons of Londo & their successours yerely for ever after their sad discrecions at their free liberte and pleasure shal and maie have and take without cõtradiction foure persons condempned adjudged and put to deathe for feloni by the due order of the Kynges lawe of thys realme for anatomies with out any further sute or labour to be made to the kynges highnes his heyres or successors for the same. And to make incision of the same deade bodies or otherwyse to order the same after their said discrecions at their pleasure for their further and better knowlage instruction in sight learnyng & experience in the sayd scyence or facultie of Surgery."*

Despite this Act the Barber Surgeons did not have it all their own way and private anatomy schools began to appear. The following is an entry in the *Annals of the Barber Surgeons. "6th March 1711. It is ordered that William Cave, one of the Beadles of this Company, do make Inquiry who the persons were that carryed away the last body from Tyburne, and that such persons be Indicted for the same . . ."* And in 1714 the following entry. *"At a Court of Assistants of the Company of Barbers and Surgeons, held on the 25th March, 1714. Our Master acquainting the Court that Mr. William Cheselden, a member of this Company, did frequently procure the Dead bodies of Malefactors from the place of execution and dissect the same at his own house . . ."* William Cheselden apologised for his breach of the Company rules and promised not to transgress again.

Not only did the bodies of these executed criminals provide the only legal dissecting material but the very act of them being "anatomised" became a recognised part of the punishment. Indeed in 1752 an Act was passed to this effect. In other words dissection was only carried out on villains, of course creating a good deal of suspicion in the mind of the layman about the goings on of anatomists. This fact was to produce a stumbling block in the first version of the Anatomy Act. Dissection of these bodies was advertised in public. The following is from the *Daily Advertiser* of January 15th, 1742. *"Notice is hereby given that there being a publick Body at Barbers & Surgeons Hall, the*

Demonstrations of Anatomy and the Operation of Surgery will be at the Hall this evening and to-morrow at six o'clock precisely in the Amphitheatre."

In 1745 the Barbers & Surgeons parted company. Naturally the Surgeons took over the task of dissecting the bodies of executed criminals. At the end of the eighteenth century a Royal Charter was sought to establish the Royal College of Surgeons in Lincoln's Inn Fields. A problem then arose in moving the bodies from Newgate to Lincoln's Inn . . . *"Dec. 6th 1796. Francis Dunn and Will Arnold were yesterday executed for murder and the first malefactors to be conveyed to the new Surgeon's Hall in Lincoln's Inn Fields. They were conveyed in a cart, their heads supported by tea chests for the public to see . . ."* The college eventually found a dissecting room closer to Newgate until the passing of the Anatomy Act in 1832 . . . *"when the College had no longer to share with the hangman the duty of carrying out the sentence on murderers who were condemned to be hanged and anatomized."* In fact the College authorities did not really dissect the bodies at all, they merely made an incision then passed the body on to the Teachers of Anatomy. The following is an example of such an order authorising the Secretary of the College to give up a body:—

"Ordered.

"That the body of Mary Whittenbach executed this day at the Old Bailey for murder be delivered (after the necessary dissection by the College) to Mr. Joseph Henry Green.

William Blizard
Wm. Norris
Anthony Carlisle

"Royal College of Surgeons,
"17th day of Sept. 1827,
"To Mr. Belfour, Secy. to the College."

It was during the eighteenth century that private schools of Anatomy were set up in opposition to the Barber Surgeons. Initially these would have been run in the teachers own home but for obvious reasons this becomes inconvenient . . .

"Anatomy.

"Designing to have no more lectures at my own house, I think it proper to advertise that I shall begin a Course of Anatomy, Chirurgical Operations and Bandages on Monday, the 11th of Nov., at St. Bartholomew's Hospital.

"Edw. Nourse, Assistant Surgeon and Lithotomist to the said Hospital."

Many such private schools opened up in the succeeding years completely independent of the hospitals and in fierce competition with each other. It should be remembered that phenol and formalin were not introduced until the latter part of the nineteenth century. Fixation and preservation of the material was practically nonexistent. Alcohol would certainly have been used, but with only limited success, it would also have been very expensive. There is an interesting account in the *Guy's Hospital Reports 1839 (vol. iv)* of various experiments carried out to solve the problem. Arsenic, lead, mercury, gall, zinc sulphate and many others were tried. These were either too toxic or they simply didn't work! Some success was achieved with creosote and pyroxilic spirit

(wood alcohol). Most of the private schools would have functioned only in the winter to help solve this problem, but it clearly wasn't completely solved until the introduction of phenol and formalin. The competition between the schools forced some of them to open in the Summer. This is an extract from an advertisement from Joshua Brookes in 1814 . . .

"Theatre of Anatomy, Blenheim Street.

"The Summer Course of Lectures on Anatomy Physiology and Surgery will be commenced on Monday, the 6th of June at seven o'clock in the morning (1979 students please note!) . . . *Spacious Apartments, thoroughly ventilated, and replete with every convenience will be open at five o'clock in the morning* (note further!) . . . *when Mr. Brookes attends to direct the Students and demonstrate the various parts as they appear on Dissection. The inconvenience usually attending Anatomical Investigation are counteracted by an antiseptic process . . ."* One wonders how effective these antiseptic measures would have been. I can't help feeling that a strong stomach was the hallmark of a good student as much as anything else.

With the ascendency of the Private Schools the demand for dissecting material rose steeply. There was no legal supply of subjects except the bodies of murderers executed in London and the County of Middlesex already referred to. These subjects were distributed through the Royal College. This number of subjects was completely inadequate. No School of Anatomy could run without subjects—dissection being considered an all important part of medical training. If the subjects could not be supplied by one school then the students would go to another. It was in this atmosphere of competition and general shortage that the sinister trade of the Resurrectionists came about.

At first only very few men were engaged in this trade, but as the demand increased so did their numbers. However, even in the heyday of the resurrectionist (early 1800s) in London only about 10 men derived their main income from exhumation, but many more would have been involved in the peripheries of the sordid business.

There are many stories about how these men went about their work. They would rob a grave or even several graves on moonless nights. The bodies would then be sold to the anatomists, sometimes for as much as 16 guineas. The body snatchers worked in gangs. There must have been many pitched battles in graveyards between rival gangs, and vigilantes. One such engagement is recalled in the *Diary of a Resurrectionist,* dated 1830 . . .

"DESPERATE ENGAGEMENT WITH BODY-SNATCHERS.—The remains of the late Edward Barrett, Esq., having been interred in Glasnevin churchyard on the 27th of last month (January), persons were appointed to remain in the churchyard all night, to protect the corpse from 'the sack 'em-up gentlemen', and it seems the precaution was not unnecessary, for, on Saturday night last, some of the gentry made their appearance, but soon decamped on finding they were likely to be opposed. Nothing daunted, however, they returned on Tuesday morning with augmented force, and well armed. About ten minutes after two o'clock three or four of them were observed standing on the wall of the churchyard, while several others were endeavouring to get on it also. The party in the churchyard warned them off, and were replied to by a

discharge from fire-arms. This brought on a general engagement; the sack 'em-up gentlemen fired from behind the churchyard wall, by which they were defended, while their opponents on the watch fired from behind the tomb-stones. Upwards of 58 to 60 shots were fired. One of the assailants was shot—he was seen to fall; his body was carried off by his companions. Some of them are supposed to have been severely wounded, as a great quantity of blood was observed outside the churchyard wall, notwithstanding the ground was covered with snow. During the firing, which continued for upwards of a quarter of an hour, the church bell was rung by one of the watchmen, which, with the discharge from the fire-arms, collected several of the townspeople and the police to the spot—several of the former, notwithstanding the severity of the weather, in nearly a state of nakedness; but the assailants were by this time defeated, and effected their retreat. Several of the head-stones bear evident marks of the conflict, being struck with the balls, etc."

One such gang operated around Guy's. Their names were Ben Crouch (Ben Crouch was the son of a Carpenter who worked at Guy's), Bill Harnett, Jack Harnett, Daniel (surname unknown), Butler, Tom Light and Hollis. Their activities are well documented in the *"Diary of a Resurrectionist"*. Honour amongst the rival gangs was not the motto of the day. Members of these gangs must indeed have been a tough and villainous lot. These are a few entries from the diary—the writer of the diary was an unidentified member of the gang.

Saturday, 28th (December 1811). *At 4 o'clock in the morning got up, with the whole party at Guy's and St. Thomas's Crib, got 6 took them to St. Thomas's. Came home and met at St. Thomas's again, packed up 3 for Edinbro., took one over to Guys.*

Tuesday, 18th (Feb 1812). *Met at St. Thomas's. Took 2 over to Guy's. Came home and settled each man's share £23.6.9d. On hand 2 open'd Large, 3 small and 3 foetus not paid, at home all night.*

*Tuesday 25th (*Feb. 1812). *At home all day, at Night met Jack to go to Harps,* the moon at the full, could not go.* (*the name of a keeper of burial ground).

Monday 16th (March 1812). *At Home all day went to Harps got 3 Large and 1 Large Small, 1 Small, and 1 Foetus, took 2 Large to St. Thomas's, 1 Large to Guy's, Large Small to Mr. Frampton and 1 small to Mr. Taunton. Mr. Frampton called at 7 in the evening.*

No date. *Tom & me went to Olives,* did not succeed* (*St. Olaves).

At first sight it is difficult to see why eminent Surgeons and Anatomists of the day were prepared to be in league with these criminals. Sir Astley Cooper is but one such Surgeon who had many dealings with the Resurrectionist. He obviously knew exactly what was going on. Not only did such men pay for the bodies, they paid the Resurrectionists retainers and also supported their families if they were caught and sent to gaol. . . . *"May 10 1827, Paid Hollis, Vaughan and Llewellyn finishing money £6.6.0"*. (this was a retainer at the end of season) . . . *"January 29th 1829, Paid Mr. Cock to pay Mr. South half the expenses of bailing Vaughan from Yarmouth and going down £14.7.0d. 1829, May 6th Paid Vaughan's wife 6s. . . ."* These are from Sir Astley Cooper's papers. The Resurrectionists had the market cornered. With the law as it was the Anatomists just had to pay up and turn a blind eye if they were to con-

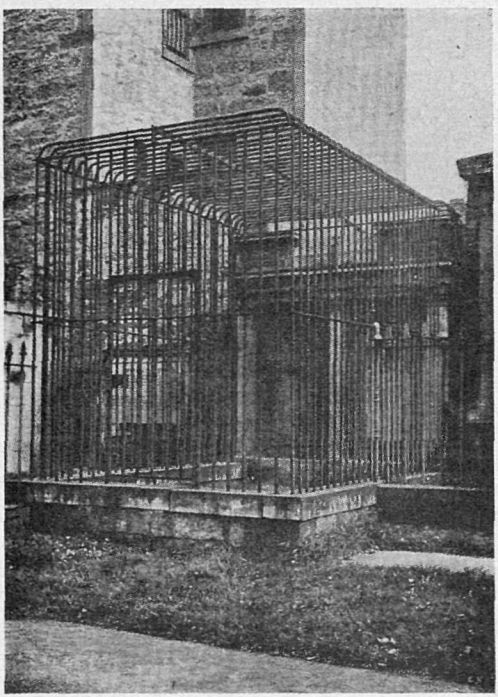
"THE BODY SNATCHERS"
A contemporary cartoon.

tinue training students. If a teacher tried to obtain from other men, the regular gang would either inform the police or they woud literally hack the body up at night in the dissecting room. This would cause unrest amongst the students who had enough to contend with in any case. The students, of course, paid fees for the privilege of dissection and would simply go to another school if too much of this happened. The teachers were thus completely in the hands of the Resurrection men. It is also very clear that the Resurrection men murdered some of their victims. It is well known that Burke & Hare who operated in Edinburgh were not really Resurrectionists at all but murderers. At least two characters in London, Bishop & Williams were the same. These two were hanged in 1831 amidst great public rejoicing. Doubtless they would have received the final indignity of being dissected!

With all these incredible activities going on it is difficult to see why the Government didn't step in and pass a law to change things. Everybody agreed that medical education was essential. The teachers most of all wanted a change. They did not like having notorious criminals in their dissecting rooms. The schools would be pestered by the morbid to view the bodies. Neither did the teachers like being part of the punishment for murder. . . .

"I certainly think that while that law remains they (the public) will connect the crime of murder with the practice of dissection. . . ." The first attempt to pass a Bill through Parliament in 1828 failed partly because executed murderers were not excluded. Another Bill was brought before Parliament despite opposition from various quarters. This

opposition came mainly from the private schools, fearing that the elaborate machinery to run an Inspector of Anatomy would be their extinction. In 1832 the bill became law and was the first Anatomy Act. An Inspectorate was set up, only licensed teachers could receive bodies in licenced medical schools. The subjects were basically the unclaimed dead. The body was given up for dissection 48 hours after death provided the subject had not expressely stated in his will that he did not want to be dissected. The Inspector of Anatomy had to be informed, a death certificate had also to be signed and arrangements would be made for a proper burial in consecrated ground. Further the dissection of murderers was done away with. The Act has been modified in only a few ways since 1832. Nowadays bodies are only accepted if the subject has expressly stated in his or her will that they wish their bodies to be used to further medical education, and of course there is still an Inspector of Anatomy. Subjects can only be accepted by a licenced teacher of anatomy and dissected in a licenced premises. They must be buried after a maximum period of 2 years at the expense of the Medical School. Needless to say a valid death certificate must be signed.



Mortsafe in Greyfriars Churchyard, Edinburgh — one of the many devices to thwart the resurrectionists.

With the passing of the Act in 1832 the Resurrectionists died out completely, and at last teaching anatomy became a respectable profession. Another change occurred at the same time, the Private Schools disappeared. As far as Guy's is concerned, until 1825 Guy's and St. Thomas' were combined as the United Hospital. Then, largely due to the efforts

of Sir Astley Cooper, Guy's split with St. Thomas'. A new dissecting room was built ready for the winter season of 1825. The site of this was where Nuffield House is now. This was expanded in 1850 and used until 1923 when the present building was completed. After 1832 despite the fact that dissection had become legal, work in the dissection room must have been very unpleasant. We have already seen that fixation of the subjects was not all that effective. One imagines that dissection had to be done as rapidly as possible, preferably only in the winter. It is not hard to see why the services of a man like Towne were so valuable. His incredible wax models made from dissections carried out by Hilton, must have taken some of the unpleasantness out of learning anatomy. With the introduction of better fixatives and antiseptics, towards the end of the last century, much of the value of these wax models was lost. It is a rare event for any of these models to be used in modern teaching, although it has to be said that many of them show structures that most of us would have great difficulty in demonstrating in even the very best material. Obvious examples of this are the lymphatics and the finer ramifications of cutaneous nerves. So perhaps we should all look at them from time to time to remind ourselves of structures we know so well but see so infrequently and pause to reflect on the skills of the men who worked in the middle of the last century.

Of course, the modern dissecting room is not without its problems. The fluid we use at Guys to preserve the subjects is a mixture of formalin, phenol, alcohol, glycerin and water. By and large this works well. The smell—mainly the formalin—is a problem but to leave the formalin out, as is the practice in the United States, produces very poor fixation and much worse problems. The solution we use unfortunately also removes all the colour and alters the natural textures of the tissues. It is very hard to see a way round this problem particularly in view of the number of subjects required each year.

Dissection, by the students, still forms the basic method of teaching anatomy, although the time given to this in the timetable is much reduced. Arguments are put forward that dissection is a waste of time and an expensive luxury. The alternative is to use prosected material and employ teachers *"to show the students round the body"*. To some extent this is already done in the form of television films. However we have had some years of experience of these films now, and I am firmly convinced that any teaching aid of this kind should only be used as an adjunct to dissection and not a substitute. There is a great deal to be said for the student finding things for himself. If the stimulus of self discovery is completely removed the student will become lazy and much less will be learnt. Although it may seem at the time that conditions in the dissecting room are somewhat forbidding, they are vastly better than in years gone by, and no one has ever come to any harm. Spare a thought for Mr. South in 1813!

Arthur Hurst - A Personal Note

by **W. N. Mann**

Arthur Hurst—from a portrait by Herkomer which hangs in the Dean's Office.

On July 23rd, 1979, the centenary of the birth of Arthur Hurst will be celebrated. Among the greatest Guy's men of all time, he is pre-eminent in this century: physiologist, radiologist, neuro-psychiatrist, gastro-enterologist and, above all, a great physician.

No one made more demands upon his juniors; no one evoked more devotion and loyalty. Everything about Arthur Hurst was stamped with his individuality, so that in no wise was he like anybody else. This was true of his speech, his manner, his appearance and even his clothes—leaving apart the more striking aspects of his personality.

He was under middle height and slight of build. His face was thin and sallow. His hair was raven black, smooth and not touched with grey—nor baldness. His nose was aquiline and angulated—as he said, the better to accommodate the gold-rimmed eye glass he wore. His eyes were light blue-grey and intensely penetrating. His figure was neat, small and rather hunched-backed from long-standing asthma. Except when breathing was difficult, he walked with an alert and almost jaunty step. He dressed most carefully. Out of doors he wore a Homburg hat, pushed back a little, or at an angle. He invariably carried a slender Malacca cane with a gold band round it. This hardly calls to mind a Bohemian figure, but at a time when many of the Staff still wore morning coats, there was individuality about Arthur Hurst's appearance and a breath of a wider

world. His voice was low and slightly guttural; his speech often elliptic. He had a tremendous, almost impish sense of humour: he often laughed; more often he chuckled. He saw everything and enjoyed much.

Early in 1935, I was a "Clinical". This was an appointment peculiar to Guy's and originated in the days when Bright set up the first Clinical Research Unit, was allotted special wards for the purpose by the rest of the Staff, and appropriate students were attached to him. This appointment persisted and, every three months, the best six students became "Clinicals" and worked in Miriam and John wards—on the third floor of Hunt's House. Each of the Physicians, senior and junior, spent six weeks at a time as Physician to Clinical, giving up all other work in the Hospital. There was no registrar and no house physician; the relationship between physician and student (who usually took the Conjoint during his appointment) was a close and direct one. Whenever the take-in H.P. was called to see a patient demanding "acute" admission, the "Clinical" went too, saw the patient first and, if he wished, admitted the patient to Clinical Ward. If he declined, the patient was admitted to the general wards in the ordinary way. It thus happened that in Clinical Ward were collected the most interesting, the most rare and the most acutely ill medical patients in the Hospital. "Clinical" was therefore an intense apprenticeship of enormous value; it was the immediate period of training before the major resident appointments. There was no hope whatsoever of becoming house physician or house surgeon on any of the general medical or surgical firms without first having been a Clinical.

I was lucky, having also been a Ward Clerk on the Hurst Firm, to work under him—or with him—as a Clinical. Early in 1935, I was walking through the Park at Guy's to his car at the conclusion of a round. We had just seen a middle-aged woman, the wife of a clergyman, with acute ulcerative colitis for whom, clearly, the outlook was grave. After walking a little in silence, he turned to me and said "You can't have ulcerative colitis if you haven't got a colon". Another pause, and then, "Ask Mr. Ogilvie to remove her colon". This I duly did and the operation, the first of its kind, was carried out in one stage in the most skilful manner. The colon was intensely inflamed and the operation was necessarily long and formidable. She died two or three days later from what was then called secondary surgical shock—a combination of blood loss and electrolytic disturbance. It was from this experience that Hurst gradually developed the surgical treatment of ulcerative colitis. At first a proximal "double" ileostomy was done, the colon was rested and washed through with saline. The rectum was treated with various local preparations (tannic acid; bismuth sub-gallate). After a suitable period, usually many months, the continuity of the colon was restored. The colitis invariably returned. Faced with this failure, the next procedure Hurst proposed was ileostomy followed later by colectomy with the hope of a subsequent ileo-rectostomy to re-establish the continuity of the bowel. While preparing the patient for the last operation, it was my duty—I had become Hurst's H.P. by this time—to snare and fulgurate any rectal pseudo-polyps which might be present. These were often many and large—like a bunch of grapes—and long and tedious these sessions were. In a few cases, the ileo-rectal anastomosis was attempted, but this always broke down. That these attempts failed was perhaps partly due to the absence of antibiotics. Although sulphonamides had been introduced and were efficacious in the treatment of many acute infections, I

do not recall their use prophylactically before an operation on the alimentary canal, or in the treatment of ulcerative colitis. In addition, there was little or no knowledge of the way in which disturbances of salt and water metabolism might profoundly influence the outcome of a major operation. Nevertheless, these ideas of Hurst's prepared the way for the operation of colectomy followed by ileo-rectostomy as the ideal sought to-day, even though it still often fails and is sometimes impracticable. It was at this stage, Hurst decided that the operation of permanent ileostomy followed by total resection of the colon and rectum was the best operation for those examples of the disease in which medical management alone was insufficient. He was the kindest of men and took great trouble in explaining matters to the patients and caring for them also. He thus obtained excellent results. He was especially proud of one of his earliest patients, a keen horse-woman who, initially almost moribund, was hunting six months later. This was something very remarkable in those days.

It was with some relief, I saw this change of emphasis from medical to surgical methods in the treatment of ulcerative colitis. Hurst had seen many cases of bacillary dysentery while serving in the Army in Salonika in 1915. For long, he could not rid himself of the idea there might be an aetiological relationship between dysentery and ulcerative colitis which their pathological similarity suggested. Hale-White, a great Guy's physician and one of Hurst's teachers, wrote on ulcerative colitis and clearly pointed out the separate identity of the disease from dysentery in 1878. Anyway, anti-dysenteric serum was in vogue during the mid-thirties in the treatment of ulcerative colitis. It consisted of an unappetising rather opaque, buff-coloured, turgid fluid which was given with saline in an intravenous drip in huge doses. I used to set up the drip always in the mornings—to be prepared for the allergic and toxic reaction which invariably followed later in the day.

Hurst did two rounds a week; one on Tuesday and one on Friday afternoon. The ordinary round took place on Friday. The House Physician met the master at the Front Lodge as he stepped from his Rolls Royce or taxi at precisely ten minutes past two. He would then go into the Superintendent's office to sign the attendance book—an immemorial and proud custom sadly now in abeyance. We then went to Hunt's House where a ward clerk was standing by the lift already called to the ground floor. The male beds were in Addison ward (the first floor ward on the North side) and the female beds in Mary (on the second floor to the South).

It is difficult to describe the intimacy of these rounds. The ward clerk always gave the history and Hurst's entire attention was directed to patient and student, referring to the house physician only for the result of this or that test, or for any further elucidation of the symptoms or signs. He would sit on the bed, hand cupped round his better ear, often one leg cocked up over the other and no patient was unaware either of the attention he was receiving, or of the stature of his physician. The registrar took no part in these rounds; indeed, the medical registrar in those days did not interpose himself at all between the physician and his house physician. The registrar registered—that is, he kept the register of patients, summarized and indexed the ward clerks' notes and taught the firm. He only gave his opinion about a patient if directly asked to do

so by the physician, in his absence. As there was then the system of four medical firms, each with "Physician" and "Assistant Physician" (the latter often very mature), and as one of the pair was always on call during the firm's take-in week, such occasions were rare. Otherwise, the registrar humbly occupied himself with out-patients and writing papers.

The round concluded, sister would pour out the warm water from ewer to basin, the carefully folded towel would be unfolded and presented and Hurst and his H.P. would walk back to the Front Lodge, either silently or with a pungent remark or, more frequently, exhausting instructions.

The Combined Round took place on Tuesday afternoons and was, I think, modelled upon rounds which Hurst had attended during his Parisian days at the great French hospitals.

Mary Ward was huge, perhaps of sixty beds or more, and in the middle was a large hall which divided it into two sections. Along one side of this ran a kitchen range where Residents on the medical side were regaled with hot drinks after their night rounds by indulgent nurses and where those same nurses, at five o'clock in the morning, prepared the patients' breakfasts and a very pleasant appetizing process it was if you had been up all night. For Tuesday afternoons, the hall was filled with light chairs, a hundred or so, and a blackboard, an x-ray screen and microscopes were set up.

At one o'clock each Tuesday afternoon, the H.P. presented himself at the Athenaeum and at 1.10 p.m. Hurst arrived and master and disciple went in to luncheon. The cold side-table at the Athenaeum in 1935 was a splendid affair and on my first visit and in my ignorance, I helped myself to a jolly good helping. Alas, I had not reckoned with my host whose exiguous portion of grilled fish, taken with Acid hydrochloricum dil., B.P.C., one drachm in a glass of sweetened fruit juice, put me to shame. There was no time to eat because, during the whole of the meal —when not greeting casual acquaintances—Hurst was asking questions and briefing himself on the cases being presented in the afternoon, for the choice of these rested with the H.P. As you had to speak clearly and loudly, this could embarrass the speaker and interest members at nearby tables. I reached my zenith when I told him I had a case of pseudocyesis in a male (a sort of *couvade*, the gradual enlargement of the abdomen being accomplished by a gradual hysterical increase in tone of the diaphragm). Hurst was sceptical at first, but the aetiology was clear and he accepted the diagnosis. Going back to his car after that combined round, he said *"Hypnotize him and show him cured next week"*. Which I did, even though the cure was a brief one.

We drove down from the Athenaeum, leaving at precisely two o'clock, and then entered Mary where the Clerks presented the cases. Hurst sat in the front row with his hearing machine, often accompanied by distinguished foreign visitors, for he was well known abroad. In particular, I remember Snapper from Amsterdam and Forrestier from Paris and Aix-les-Bains (still, I hope, well known to rheumatologists). The cases were demonstrated and discussed. On occasions, other members of the Staff would be invited, or summoned rather, by the H.P. to attend. They were sometimes reluctant to come because, although Hurst was always courteous in the extreme, encouraging and attentive

to the halting words of his juniors, he could be abrupt and chilling to his contemporaries. The usual way of showing displeasure or boredom was to turn off the hearing machine and carry on a conversation with someone nearby.

It was with relief that I saw Hurst drive away at the end of a Combined Round. Hungry and exhausted, it was my custom to go to the warm and friendly College for a substantial tea. But all was not yet over. Hurst was a confirmed theatregoer and, not infrequently, before tea was finished, he would be telephoning from the Metropole Hotel to ask if I would find his hearing machine and bring it to him in the foyer of the St. James's Theatre, or the Lyric, or wheresoever it was, in time for the 8.30 performance that evening. By train and bus and on foot, the pale H.P. would stand there till the cortege arrived, the box accepted and muttered thanks given. Then the bearer obliterated himself in the dank and dark London night.

During the development of the operations for ulcerative colitis, Hurst was very certain what he wanted done and instructed the surgeons what they had to do; moreover, he made sure they carried out his instructions. Joey Hughes and Heneage Ogilvie were those he generally asked to do his operations. When a colon was to be divided or removed, it was my duty as H.P. to tell the surgeon that Sir Arthur would be in the theatre at two o'clock. We would go straight to the theatre on his arrival—ten minutes late. If the abdomen had by then been opened, it would be packed with hot towels and the surgeon might instruct the waiting surgical firm with a dissertation on the varieties of hernia. Hurst would arrive, put on cap and mask and gown—and gloves which sometimes tore. It might happen that his eye glass was somewhere in his waistcoat pocket into which a gloved hand would plunge to fix the glass in his eye. With forefinger poised perilously within the abdomen, he would indicate where ileum or colon were to be divided and only when the irrevocable cut had been made would the Medical Firm withdraw and the Surgical Firm be left to their coarser procedures.

But the great surgical adventure was what may have been the first laparoscopy—note well, in 1935. There was a woman in Mary ward with a lump on the liver which had defied diagnosis. Hurst hit on the idea of having a look at it *without telling anybody.* I was enjoined to borrow an operating cystoscope from Theatres without saying why; in retrospect, I cannot imagine how I managed this, but borrow it I did. The time for the venture was a Saturday morning (a time when Hurst was never ordinarily in the hospital) and the venue was the small theatre attached to Mary ward. As H.P. it was my duty to make a hole in the abdomen under local anaesthetic so that the instrument could be inserted. In case my readers think this shows unusual temerity, any H.P. in those days had done appendicectomies, herniotomies and a host of operations of that kind as Dresser and Assistant House Surgeon, so making a midline hole in the abdominal wall offered no difficulties. We were dressed up in gowns and masks and behaved like Guy Fawkes conspirators. There were three of us there and sister. Hurst put in the cystoscope, looked down the telescope and announced that she had indeed a lump on the liver and that he still did not know what it was. Thus another step on the road of surgical progress had been taken.

These notes can hardly convey the kindness of Arthur Hurst and

the help he gave to his juniors. You had to work very hard. When he was confined to bed with asthma, the dreaded postcards would arrive —sometimes two or three in one day. "Please look up the last two hundred admissions for duodenal ulcer and let me know the sex incidence by Friday". And so on. But there was the other side of the coin— dinner at the Metropole Hotel, evenings at the theatre, supper at the Café de Paris and luncheon at Ascot. It is possible to draw only in pastel here the vivid colour of this marvellous man. He profoundly influenced all who worked with him; his boundless vitality and enthusiasm exceeded those of his juniors and, like the Greeks, he ever sought some new thing. His intellectual achievements were equalled by his humanity, his humour and a relish for life.

Language and the Law:

A talk given to mark the 21st anniversary of Quodlibet on 23rd May

By PROFESSOR KEITH SIMPSON, C.B.E., M.A.(Oxon), LL.D.(Edin.), M.D.Lond., F.R.C.Path., F.R.C.P.Eng.

Our reviewer writes:

It was an irony that Professor Simpson's talk entitled *"Language and the Law"* should have been prefaced by a verbal dispute in that we heard two accounts of the meaning of *"Quodlibet"*. Richard Trembath's offering of *"what you will"*, supplied in his introductory remarks, seemed to me to have stronger links with Shakespeare than with accuracy, as those familiar with *"As You Like It"* may testify. Appropriately it was Professor Simpson who gave the more accurate version; *"may it please you"*.

Professor Simpson's theme, the importance of *"the skilful use of appropriate words"* and for linguistic accuracy in general, was presented in an anecdotal, ruminative manner that was so relaxed it almost obscured the seriousness of what he was saying. It is not a criticism but a fact that this idea, that effective communication is parasitic upon succinct expression, is not novel. Professor Simpson acknowledged this in his quoting of Samuel Johnson's slogan *"languages are the pedigree of nations"* but one could easily locate similar sentiments in almost any other literary source, such are their ubiquity. *"Clarity of thought in construction . . . a correct choice of words . . . connected logically . . . is the substance of effective speech or writing."* Professor Simpson is right, notwithstanding that he treads a well-trodden path. If the Bible is to be believed the construction of the Tower of Babel was hampered by the hod-carrier not knowing what the works-foreman was talking about. From St. Augustine to T. S. Eliot's *"intolerable wrestle with words and meanings"*, through the entire tradition of 20th century analytic philosophy, the linguistic structuralists and finally to Professor Simpson himself, the interest and pre-occupation remain.

Professor Simpson considered these points with regard to the

advocate in court whose success ultimately rests on *"his feeling for the precise meaning and use of words"*. Lord Denning made a rare excursion into autobiography in his recent publication *The Discipline of Law* and his comments, particularly in chapter one, *"Command of Language"*, read as though they fell from Professor Simpson's pen. *"To succeed in the profession of the law, you must seek to cultivate command of language. Words are the lawyer's tools of trade."* One is reminded of Ivor Brown's remark in his book *"A Word in Your Ear"*:

"The craftsman is proud and careful of his tools: the surgeon does not operate with an old blade: the sportsman fusses happily and long over the choice of rod, gun, club or racquet. But the man who is working in words, unless he is a professional writer (and not always then), is singularly neglectful of his instruments". If the purpose of speech is to transfer an idea as accurately as possible out of one mind into another, then the thesis that linguistic precision is the condition of effective communication should hardly need arguing for. Of course, the emphasis on linguistic accuracy does not imply that all language is declarative, is fact-stating.

Professor Simpson gave us many examples of what he termed the Art of Persuasion, of language in its cajoling function, all of which illustrated the old adage that the adjective is the enemy of the noun. The advocate, in opening a case, states, *"those are the facts my Lord"*, as if to say that what follows is a fictitious creation of an overworked imagination. Rather, he seeks to shift the emphasis by a Wordsworthian colouring of the imagination, avoiding the latter's *"gaudiness and inane phraseology"*, and suggesting a new interpretation of those facts. Thus the great advocate Marshall Hall interpreted the words "How could I kill this child", *not* as How? (method) but How! (incredulity); how could *anyone* kill a child as beautiful as this? As Professor Simpson wryly observed, Doctors are seldom so devious!

Professor Simpson devoted some few minutes to an area that has always seemed so radically misunderstood, particularly by the "define your terms" neurotics—the Theory of Definition. Indeed these individuals seem to regard it as a happy hunting ground for semantic fractiousness and as a barrier to any dialogue at all; we are condemned by the O.E.D. into a state of linguistic solipsism where talking to oneself is not a sign of madness but an ineluctable consequence of *"what do you mean by? . . ."* This is a topic of high general relevance in law, not only with regard to the construction of statutes and, therefore, their interpretation but also in actions for defamation of character, that is, libel and slander. Professor Simpson pointed out that the action is founded not so much on the meaning intended as on that conveyed; not so much on what you meant but on what I took you to mean, *"for it is the latter that causes the actionable hurt"*. It will be vital therefore, to consider the words in the context in which they are used and not as verbal pariahs that are content with a life of splendid hermitic isolation. Professor Simpson's discussion recollected one of the hardy annuals of linguistics examination papers; *"If you are so sure you know the meaning of this word give me a definition of it. Is this request always fair?"* As he noted, not only is it not always fair (define *"blue"* for instance) but the meanings of some words are better grasped by giving examples of their use than by consulting a lexicon. In this way we might, if fortunate, avoid the mesmeric

influence of abstract nouns such as "freedom" and "democracy", and of the word *"fascist"* it now seems pertinent to ask not *"what do you mean by it?"*, but *"what can be meant by it?"* Kingsley Amis smugly observed that a fascist is anybody who is in power.

These points, and more, were attended to by Professor Simpson in a talk abounding with pieces of recondite information; the serious conclusion is *"the English language has so often achieved greatness in the Courts of Law"* by the pursuit of high standards of expression and the recognition that as the possibility of ambiguity increases, then so does the need for accuracy.

D. E. Moss adds . . .

"Odi profanum vulgus" said Horace, *"et arceo"*. I loathe the common herd, and I drive them away. Thus Leigh Hunt began his dissertation *"On the graces and anxieties of pig-herding"*, and of this one was forced to contemplate by the nature of Professor Keith Simpson's anniversary address to the Quodlibet Society.

A classical tone was inescapable, since, in his unfortunate introduction, the Chairman, Mr. Trembath, suggested *"what you will"* as a definition of Quodlibet. Professor Simpson rightly amended this to a more accurate and apposite *"may it please you"*, that current court archaism so frequently heard. Professor Simpson then launched a convoluted rhetorical Sputnik, wherein the nature of speech and communication was discussed—if not *seriatim*, at least with *succès d'estime;* if not concatenated, at least *con amore;* oratorial, orotund, and—as one would expect—liberally anecdotal.

I attempt no discussion of the speech, the comprehensiveness of which was startling, and is discussed above. Sins (if any) were, alas, of omission—presumably by pressure of time. A shame, since one would have wished to have heard Professor Simpson talk more about the matter in hand. The only other thing to mar this display of erudition was the omission of the essential ergo in that famous Latin tag *"post hoc ergo propter hoc"*. Nevertheless, in these days of declining interest in Litterae Humaniores, how pleasant it is to hear someone attempting to inculcate the intrinsic beauty of the Classics into the next generation of doctors.

Congratulations to the Quodlibet Society on their 21 years of life—albeit intermittent and intersculatory—and also a devout hope that they shall continue, to see their 25th, 50th . . . 100th anniversaries, and that their anniversary addresses will be as thought-provoking. Nevertheless, one did find it difficult to understand why—for their anniversary—they decided to return to the hospital for a speaker to talk outside his usual field, when their history has been to broaden outlook by inviting outside speakers to talk on their specialities. They were, fortunately, proved right on this occasion—for Professor Simpson displayed that his speciality could be likened unto that of Mycroft Holmes—omniscience—and this carries not the slighting Parthian shaft of "master of none", since Professor Simpson is irrefutably the master of forensic pathology.

Films

A recent article in the *New Statesman* examines a change in North American television screening tactics: the "mega-production". This was introduced to combat the low ratings gained by big running 30 episode serials, and at the moment is being tested on Monday nights, as a result of the success of such prototypes as **Roots, Washington Behind Closed Doors,** and **King.** Larry Cohen's latest film, **The Private Files of J. Edgar Hoover,** is the film industry's version of this weapon.

The film opens with a very well constructed montage of shots taken from odd angles, which is followed by an original piece of documentary film of Hoover's eulogy given by the infamous R. Nixon. However this optimistically excellent opening soon lapses into a television "mega-production" screenplay, as the film returns to review Hoover's work and life. His biography provides a good skeleton onto which Cohen has subtly grafted many ideas, some of which he proceeds to expand upon. These ideas and suggestions are well presented by Broderick Crawford, who portrays Hoover in the film.

Although no explicit comment is made about Hoover's sexuality, the subject, without any doubt, is considered. On two occasions, once at the beginning and once at the end, Cohen confronts Hoover with two eagerly receptive women, both of whom he emphatically refuses with a feeble excuse. Also, between these two incidents, Cohen has Hoover's sexuality questioned amongst his aides, and then a few frames later, it is discussed by Hoover himself. Many other aspects relating to Hoover and the F.B.I. (the two are practically synonomous for most of the film) are covered; especially the Kennedy brothers and Martin Luther King.

By the time R. Nixon had reached the White House, Hoover was the most powerful man in the U.S.A., holding private files on anyone that he considered to be a threat. Nixon, because of his problems with the F.B.I., set up his own band of telephone tapping and hotel bugging spies, who were kept very busy until they were caught working one night by a hotel guard.

This is possibly the only fault of the film; due to the mental effort involved in following the complete American politics running through the film, one was not allowed to become bored. However even a scanty knowledge (such as mine) should alleviate the problem.

In conclusion, although no definite social or political comments are made, (and I think that maybe they should have been), Larry Cohen has succeeded in producing an excellent, well-balanced film.

Phillip Howell.

Nursing

This morning, from my ward, I telephoned one of the laboratories to ask for a particular sort of specimen collection bottle. "*Oh yes*" came the answer, "*could you send a nurse?*" I explained patiently (I am only

patient now because I have become bored with saying the same thing so often) that: (a) my nurses were far too busy nursing to spend time portering and (b) they had a porter in that department so please would they send it with him *"Oh yes of course"*, they said as if they had not thought of it.

This sort of occurrence is so common in the hospital, that, even though I was told by one senior colleague not to use this column as a grumbling page, I feel that I must jump on my soap box about this particular grumble.

Of course the department knew that the porter would do it, but for some reason they seemed to want to spare him work. It is certainly worth their while to try it on, because many of my less wily colleagues, especially junior staff nurses or head nurses in charge of wards, don't think about arguing but just send a nurse.

Often it is not as simple as this, and the department say that the porter is busy/sick/unavailable, so unless a nurse will take the patient/specimen/x-ray, the investigation will not be done. They know that this sort of blackmail is very easy to use because nurses actually care about their patients and don't like them to miss important investigations or treatments. However, a word to the unwary—if it is not urgent that the patient goes to the department at that minute, hold out and say you *can't send a nurse* (you usually can't without great difficulty and neglect of other patients). You will be surprised how often the sick or busy porter does actually turn up within about five minutes.

I realise that nurses are not the only people to suffer in this way. Of course the house officers are the biggest dogsbodies in the hospital. They not only care about their patients but will also get into trouble from their seniors if the investigation is not done. Often the nurses run the errands because they are sorry for the house officer and know that he has less time than they do. Perhaps other people could share the burden a bit more when there is a porter shortage. When, for instance, did you last see a student radiographer bring a film back to a ward instead of a student nurse going to fetch it?

I am not suggesting that nurses should be cheese-paring about who *does what, like petty union officials. On the contrary I think that* a hospital will only run efficiently and happily if everyone helps each other out when there is a particular need. Nurses have a special commitment of 24 hour service to the patient and this has a special reward of a close relationship with him, which is not usually given to other hospital staff. This sort of commitment means seeing that every need of the patient is met, however this is done. But if nurses let themselves become the general errand runners of the hospital when this is not necessary, they will not be meeting more important needs of their patients. We constantly need to spell this out to people in other departments and tell them that we too have a specialised job, and there are only just enough of us to do it.

Julia Fabricius.

Physiotherapy

Post Registration Training

Continuing education for physiotherapists, as for any other group of professional workers, should be systematic and able to develop along recognisable lines. Unhappily, the way in which our training has evolved has produced a qualification which is in the nature of a blank wall in that there is no further course to be followed. Others, having obtained a first qualification or degree, can continue to a second or even a third, but for us this is not so. True, we have a Fellowship which may be awarded by the Society, but the routes by which it can be approached are such that only a handful can hope to achieve this status. Not that that is necessarily a bad thing—a Society in which the top distinction is too easily achieved would quickly have to invent a further one—but it would seem desirable that some distinction intermediate between the basic membership and the fellowship is devised.

One way this may be done is by setting up nationally-recognised and validated courses of post-registration training, and the Chartered Society has a sub-committee working on this problem at present. Meetings have been held with representatives of the medical profession, education, research and the DHSS, and with the National Training Council. In collaboration with the occupational therapists and remedial gymnasts, the Society has put forward proposals which the D.H.S.S. has accepted, and a grant has been made for the development of continued education programmes and validating procedures.

As a result, an educational development officer for the three remedial professions has been financed.

Standards Committees have already been set up by the C.S.P., the first for Manipulation Education, the next two for Respiratory Care and for Community Physiotherapy. A guide to the running of courses is in preparation and it is hoped that ultimately progression through the ranks of the profession will be signalled by the acquisition or development of skills imparted by properly validated courses supervised, if not actually conducted by, these Committees. End of course examinations are held, and already we are expecting that a Senior physiotherapist taking charge of the "mobilisations" section of our departments should be one who has successfully undergone this further training. As yet, we are not in the same position when it comes to all the other specialised fields, but "specific interest" groups are in existence—some, like the Obstetrics and Gynaecology group, for thirty years—and we would not expect to appoint a senior to, for example, a paediatrics job who was not a member of one of these groups.

At Guy's, we hope that we are going to be able to play our part in the development of post-registration education, and negotiations are presently in progress which we would like to see come to fruition before the end of this year. We are, in common with many other departments in the District, on the visiting-list of many practitioners from abroad and from other parts of the United Kingdom, and we hope that we can formalise the present *ad hoc* arrangements made by individuals into a part of a structured system of further specialised training with national recognition.

Ronald Cooper.

Book Reviews

"Paraplegia—a handbook of practical care and advice", by Michael A. Rogers. Pp. 66. Price: £2.95 (soft cover), £4.95 (hard back). Published by Faber.

Anyone inflicted with paraplegia or tetraplegia goes through a most difficult period of psychological and physical adjustment if he is to return to a meaningful and rewarding existence. This book, as its subtitle implies, is a compendium of useful advice and information, which ranges over every aspect of the life of the affected individual. It is written in an authoritative and easy style by a man who learnt "the hard way" as a tetraplegic patient. In addition to providing chapters on specially important subjects such as the care of the bowels and bladder, the prevention of pressure sores, it provides detailed information on modification of the home and work and on all aspects of transportation both within and outside the home. There is a chapter on sex and the paraplegic—a subject which was formally a taboo. In addition there is a useful glossary and appendix extending over twenty pages of names and addresses of organisations, agencies and firms that can be of service to the paraplegic at one time or another.

This book should be read by all paraplegics and their close relatives and friends. It has much to commend itself to the reading lists of General Practitioners, nurses, physiotherapists, occupational therapists, social workers and hospital specialists dealing with the paraplegic and tetraplegic. Medical students will also find much of value in this book in an area which is often given scant attention during their undergraduate training period.

R. GRAHAME.
Consultant.
Arthritis Research Unit.

"Nurses' Handbook of Current Drugs", 3rd edition, by F. B. Gibberd and R. D. Tonkin. Price: £3.50. Published by Heineman, 1978.

This little book has now been brought up to date. It contains general descriptions of the action of certain types of drugs, together with lists of drugs with similar actions. After a brief introduction there are chapters ranging from those on drugs used to combat infection, drugs affecting the nervous system, cytotoxic drugs to local applications. There is also a very brief chapter on preparations used to replace electrolytes.

The book is small, well produced and clearly set out; the drugs mentioned are given both their approved and trade names, and the index is good. The descriptions of the actions, uses and dangers of the drugs is very brief indeed, and the nurse using this would need to supplement the information given by further reading elsewhere. The chapter on electrolytes is tantalisingly brief.

However, provided the nurse accepts the limitations which the authors have deliberately set and expects to use it in conjunction with a more detailed textbook, it is an excellent and useful little book, providing a comprehensive range of information about drugs in an easily assimilated and "handy" format. The important points are made clearly and succinctly. One could have wished for a little more flesh on the bones of such a splendid skeleton, but one cannot blame a book for doing what it sets out to do and nurses would certainly find this a useful one to have in the ward library.

B. B. WHYTE,
Director of Nurse Education

"Paediatric Nursing", 5th edition by Margaret Duncombe and Barbara Weller. Pp. 484. Price £2.25. Published by Bailliere Tindall, 1979.

The first edition of this book was published in 1961 and quickly became established as a standard textbook. In his foreward to that edition, Dr. Philip Evans stated that it was intended for: "Nurses who mainly look after adults, but have children in their care". However it soon became apparent that the readership would be far wider than this particular group and nowadays it is recommended to be used by all those who take responsibility for the care of sick children, whether or not they have specialised training in this work.

The fifth edition of Paediatric Nursing has been considerably revised and much new material has been included. More emphasis has been laid on the preventive aspects of paediatrics, in addition to which, new developments in nursing techniques and medical treatment have been added. Many new

illustrations have been used in order to clarify the text.

The style of writing in this book has always been clear and easy to comprehend. Despite the increased size of this new edition none of this clarity has been lost. Trainee nurses of all grades will continue to find it extremely useful and so probably, will those responsible for their tuition. At the moderate price of £2.50 it will, no doubt, find it's way on to the bookshelves of both these groups and also of anyone who has at any time, the need for guidance about the care of the sick child.

PAM JEFFERIES

(Our last Nursing Correspondent)

"Special Physical Education: Adapted, Corrective, Development", 4th edition, Pp. 414. Price: £9.25. Published by Saunders.

This book covers physical education for the handicapped in all its various aspects. Although geared towards the American system of recreation and education the overall picture presented by the wide coverage of fields of activities from which any individual may benefit, builds an excellent background to viewing movement as an integral part of the handicapped person's education and not just as a casual extra.

Although directed towards physical educationists, the book should prove useful to all people concerned in helping the physically less able to enjoy exercise to the limits of their ability.

Physiotherapy students, whilst particularly appreciating the chapter on motor learning and perception, would find the section on developmental patterns too brief.

Similarly, the section dealing with conditions leading to impairment of movement is too superficial to add much to their repertoire, and one might think that the little knowledge imparted could be dangerous in the hands of some of its recipients in the PE field.

However, the chapters concerned with modifications of dances, games, sports and activities would be of value, and would encourage those with whom the handicapped come into contact to think in terms of what can be done rather than of what cannot.

On the whole a book worth reading by anyone concerned with handicapped people, especially those aiming to help them enjoy as full a life as possible. It is good to find an approach which recognises both the mental and physical problems the handicapped have to overcome.

M. D. SKEET,
R. J. COOPER,
Dept. of Physiotherapy.

"The Geriatric Patient". Edited by William Reichel. Pp. 233. Price £14. Published by H. P. Publishing Co. Inc. New York.

My first impression of the book is that it is very well produced with type that is easy to read, tables that are often coloured and so stand out from the text and superb illustrations. Many other textbooks would benefit greatly by adopting this format.

The emphasis throughout is of an investigative approach to illness in old people accompanied by an humane attitude; considerable stress is given to recognising and avoiding the "wastebasket" diagnosis (dustbin diagnosis to us). I particularly liked one contributor's comment "A physician's scientific and humanistic resources are tapped by the elderly patient. The response can be medicine at its best".

There is little transatlantic difference with regard to multiple pathology and non-specific presentation of illness in the elderly but there are clearly differences in the style of medicine. The emphasis is often upon the self-reporting of illness in the practitioner's surgery and little mention is made of domiciliary problems and emergency admissions. This may well explain why falls, incontinence, and pressure sores are not dealt with in any detail nor is there much discussion about fractures. Surprisingly there is little mention of malnutrition and osteomalacia hardly appears even as a word, let alone a diagnosis to be considered. However, sex counseling (sic) is included as some recompense!

Twenty seven authors contributed and there is obviously variability of writing between chapters. Americanisms tend to upset me, particularly the chapter titles, "Postmenopausal Gyn Problems" and "When to Institutionalize".

My conclusion is that this is a most interesting book which should be found in a medical library. The price is high (£14) but the majority of the pages are of great value.

D. CORLESS,
Consultant, Dept. of Geriatrics.

"Paediatric Diagnosis and Treatment", by N. M. Jacoby. Pp. 472. Price: £15.00. Published by Pitman Medical.

The author recommends his textbook to senior medical students and to practitioners who are non-paediatricians. The information contained is predominantly based on the vast personal experience of the author at a famous children's hospital and a suburban practice. No claim is made to enlighten the reader on the more recent or scientific advances in paediatrics. Dr. Jacoby admits that many viewpoints especially those concerning treatment are personal and therefore controversial. Large areas of paediatrics are not covered including diseases of the skin and eye, neonatal care, development assessment and psychiatric disease in children. If this diagnostic aid is to be useful to those for whom it is recommended coverage of some diseases of the largest organ of the body as well as classification of handicapping disorders is essential.

Diseases of individual systems are reviewed chapter by chapter and the reader is left in no doubt about the literary capabilities of the author. Unfortunately facts are too frequently clouded by anecdotes and quotations. There is however a well constructed chapter on diseases of the heart by Dr. Douglas Pickering a co-author.

In summary, too much emphasis is given to classical descriptions of classical diseases, no longer a dominant feature of paediatric practice in the 1970's and 1980's.

The book is not to be recommended for the medical student reading paediatrics for the first time. There are better and cheaper concise textbooks to be read when time is at a premium.

R. S. TROMPETER,
Lecturer in Paediatrics.

"Genitourinary Cancer", by Donald G. Skinner and Jean B. de Kernion. Pp. 567. Price: £22.75. Published by W. B. Saunders Co. 1978.

This is a good book which will appeal to urologists and those oncologists and radiotherapists who treat carcinoma of the urinary tract. It is expensive and because it is concerned with the modern management of malignant disease it will date rather quickly. For instance, staging of carcinoma of the prostrate by pelvic node dissection has already been abandoned in this country because of its high morbidity.

The work suffers from being written by thirty-five authors so that there is, in places, an unnecessary overlap, e.g. there are seven chapters on carcinoma of the prostate by different authors, albeit all experts in their own field.

It is odd but true that American urology is different from British urology in spite of the very free exchange of ideas between the two countries. This book puts the American case very thoroughly and well. Classification of bladder growths and testicular tumours has never been the same in America and Britain, which often makes comparison of series confusing. On the whole, management is more aggressive in the United States. Few surgeons in this country would accept that total prostatectomy is the treatment of choice for early carcinoma of the prostate, or that there should be complete node dissection of the great vessels when nephrectomy is performed for adenocarcinoma of the kidney, and even for papillary growth of the renal pelvis. Retroperitoneal lymphadenectomy is recommend in all early teratomas of the testes and a "de-bulking" operation even when there is evidence of mediastinal disease. "De-bulking" is also suggested when there is massive retroperitoneal spread from the seminoma.

The management of bladder cancer is predictably more aggressive with preoperative radiotherapy and total radical cystectomy advocated more commonly than here.

Where this book is valuable is that it puts together, for the first time, all the aspects of the management of malignant disease of the urinary tract. There are chapters on immunology, and chemotherapy as well as more orthodox surgical treatment and radiotherapy. In recent years, there has been a spectacular advance in the management of Wilm's tumour and testicular tumours as a result of better combined therapy. This experience may help in the management of malignant disease elsewhere in the urinary tract. The last chapter, on the palliative care of patients with terminal cancer, is masterly and balances the more aggressive approach in some of the earlier chapters.

In summary, the book is excellent and should be used and referred to by all British urologists and oncologists who will treat urological carcinoma.

C. H. KINDER,
Consultant Surgeon,
Dept of Urology.

"Human Physiology", by O. C. J. Lippold and F. R. Winton. Pp. 514. Price: £10.40. Published by Churchill-Livingstone, 1979.

This, the seventh edition of this book, appearing only five years after a reprinted previous edition implies that it has had a successful recent history. There are seven contributors to this edition which is aimed at "students of medicine, dentistry and the biological sciences". The text is divided into six sections based, not on systems as in classical physiology teaching, but under such headings as cellular environment and its control (kidney, waterbalance, acid-base etc.); transport in the body (circulation, respiration, gastro-intestinal tract) and a refreshing and original section on compensatory adjustments and reactions to injury which includes immunity, shock, transplantation, pain etc.

The chapters are in the main short, the diagrams simple and clear, and the text has an easy style, for the most part, despite its multi-authorship. The contents are up-to-date, but do not include irrelevant detail. It was good to see a competent section on muscle physiology which many standard text-books tend to dismiss in a brief paragraph or two. Feedback was also fully considered but the value of the mathematics of this, which is included, is very doubtful. It was frustrating to read names and dates in the section on the gut but no immediate means of obtaining the detailed reference. The section on the nervous system was unrelieved by many diagrams or by chapters as short and convenient as in the remainder of the book. Perhaps as an indication of the author's view of their potential reader there was a page devoted to alcohol metabolism and less than half a page to hunger and appetite!

This book must be a serious competitor to those currently used by medical students and, in addition, and unlike many other physiology textbooks it will appeal to the dental student. It contains the basic and essential facts for medical and dental students, these facts are well presented and the whole book has a "lightness" about it that will encourage reading.

I. MACDONALD,
Professor, Dept. of Physiology.

"Advanced Exercises in Diagnostic Radiology: The Cervical Spine in Trauma", by Gerlock, Kirchner, Heller and Kaye. Pp. 167. Price: £6.25. Published by Saunders.

The nightmare of most Casualty Officers is to send home a patient who then dies because of a missed diagnosis. This disaster certainly does happen, and neck injuries are the commonest cause. Advanced Exercises in Diagnostic Radiology will do a great deal to allay the fears of the Casualty Officer, and undoubtedly will protect patients. The book adopts a stimulating method of presentation. The normal appearances of radiographs of the neck are explained with photographs and diagrams. Radiographs of various types of fractures and dislocations are then shown and the reader is asked to comment. There is even space for the comments to be written down. The radiographs are then discussed in detail and the chastised reader is shown his errors.

I strongly recommend the book for Casualty Officers and for junior Orthopaedic Surgeons. They will find it a stimulus to critical inspection of radiographs and a comfort in moments of stress.

MICHAEL WATSON,
Consultant Orthopaedic Surgeon.

"Elements of Medical Genetics", 5th Edition, by Alan E. H. Emery. Pp. 243. Price: £3.95. Published by Churchill Livingstone, 1979.

The fact that the latest edition of this book shows very little change from previous editions is simply a reflection of the proven worth of the basic content. This particular book is one of only a few which I am happy to recommend to the student faced with the wide choice of genetics text books available today.

I like Professor Emery's style of writing which results in a very readable text, although at the same time allowing one to use the book for reference to specific topics without having to search from cover to cover. The content is well balanced and although the author indicates that he has not attempted to deal with all aspects of medical genetics, there is adequate coverage of all the essentials that I would expect the medical student to know.

Useful features of the book include sensible lists for further reading with each chapter, together with a glossary at the end.

M. G. DAKER,
Paediatric Research Unit.

"Medicines—A Guide for Everybody", 2nd Edition, by Peter Parish. Pp. 461. Price: £1.95. Published by Penguin, 1979.

This book is written primarily for "the lay person . . . people who have

no medical training or knowledge" but also hopes to "benefit doctors, pharmacists, nurses, medical students and others". The aim of improved communication between patients and prescribers is most laudable since in general, patients remember less than a half of the information imparted during an interview with their doctor. If successful it could, by producing increased awareness of drug efficacy and the limitations of therapy among consumers, result in a reduced potential for adverse drug reactions. A major obstacle to this goal is the differing degrees of knowledge about the human body which exists within the general population: even highly educated persons may have only the haziest ideas about the functions of various organs and the nature of disease. To attempt to enlarge this primary audience to people working within the medical field is perhaps to invite disaster.

The book is divided into three sections which if it were a textbook of pharmacology would be entitled: basic principles, therapeutics and pharmacopoeia respectively. Much of the text is excellent value for the intelligent layman and there are clear expositions of important topics such as oral contraceptives, over-the-counter preparations and drug dependence. My criticisms are mainly concerned with either specific items (or perhaps more accurately where Professor Parish's opinion differs from mine) or with the strains imposed by catering to such a wide audience. For example, I would not award methyldopa the accolade of "a most useful drug" and I wonder why no mention is made of its important side effect of depression which has resulted in its declining use. In the same chapter I feel more should have been said about hydralazine (which incidentally is now spelled with only one l) which is widely used in more severe hypertension. It is certainly untrue that it must be "used in large doses" and in fact its mode of action is known. In passing, I would also mention that prazosin should not cause excessive hypotension when used "in its recommended dosage". In a book for laymen, and therefore principally outpatients, I wondered why the use of lignocaine in arrhythmias was discussed quite so fully. As it can only be usefully employed intravenously in this circumstance, most patients on the receiving end are unlikely to be well enough to want to read a book about their treatment. I would have thought more emphasis on oral drugs such as mexiletine and disopyramide would have been more appropriate. Surely it is also inappropriate to include ganglion-blockers which have only specialist uses in present-day practice.

The opinion of a Guy's pre-clinical student who read this book critically was that it tends to go into too much detail in some places and not enough in others for it to be a useful introduction to drugs for medical students. I think this is about right for our specialist audience. The fact that this book has achieved a second edition in three years, however, suggests that it fills a real need for the population at large and it can be safely recommended for this purpose (except to hypochondriacs, who probably already have the first edition!).

HOWARD ROGERS,
Department of Clinical Pharmocology.

Correspondence

An offence, is the Spit?

Sirs,

One was fascinated to read the objective price comparisons, so ably collated by the Dean, in the last issue of the *Gazette*. One wonders if he has recently eaten in these other University canteens —or, indeed, in the Spit. If he had, he might have been less likely to publish these price comparisons, since—if one is served something unappetising (if not inedible!)—the low cost is immaterial. One would be happy to pay slightly higher prices for food which one could contemplate without reverse peristalsis.

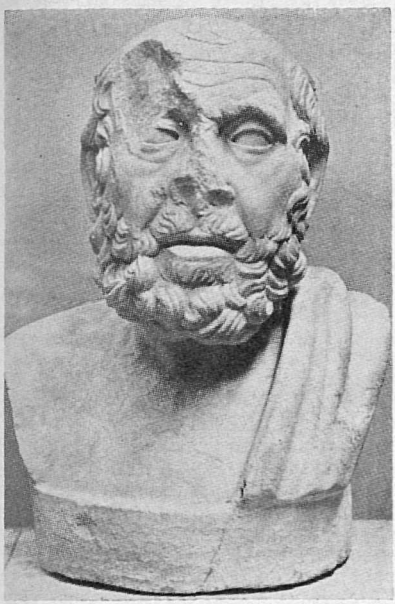
It is reported that Dr. Houston is on the recently-formed committee considering the rationalisation of hospital catering services. One trusts that, in fulfilling this task, he will not only use his financial acumen, but also his not inconsiderable gourmet sensibilities.

Yours sincerely,

M. POWLSON,
Vice-President, Clubs' Union.

Boland House,
Guy's Hospital,
SE1 9RT.

Keats' House Carvings



HIPPOCRATES.
From "The Medical Works of Hippocrates", translated by John Chadwick and W. N. Mann, Oxford, 1950.

Sirs,

I found the article by Mr. Orde and Mr. Pini on the "Keats' House Carvings" of great interest. I think the authors are correct in believing that the "Homeric figure" is a portrait of Hippocrates.

About thirty years ago, a portrait bust was discovered near Rome. It is now in the museum at Ostia. It is a fine piece of work, better, I think, than the Uffizi portrait. The facial characteristics are very similar—and to the Keats' House roundel.

Yours faithfully,

W. N. MANN

Keats' House,
Guy's Hospital,
SE1 9RT.

The Snowflake Ball

Sirs,

Immediately after Robert Peck's letter concerning the mishaps that occurred during the last Snowflake Ball appeared in the March *Gazette*, I approached one of last year's organisers, and asked him to write a reply—which he said he would do. As he had failed to do this by the next issue I re-reminded him, obviously he again neglected to carry out this task.

Neither I, nor any member of the present Clubs' Union Council had anything to do with the last Snowflake (I did not even attend) so I cannot answer any of Robert's questions about problems that occurred on the night. However, I can inform you that about £450 was made, mostly because of artistes failing to turn up. In a meeting of the Clubs' Union Council held last January it was decided that a refund was impracticable and would only amount to about one pound per couple who bought a ticket. This Council decided also that the money ought to be put on deposit as a buffer against future losses. Since January things have changed, for a start a completely fresh executive has taken office and the strength of student opinion (expressed by union representatives as well as by Robert) with regard to the last Snowflake has become apparent in a way that was not clear in January.

As a result of this we had a discussion at the last Clubs' Union Council about what best to do with the money. This discussion was cut short by the Chairman's other engagements, so we did not reach a decision. No doubt, however, we will decide what to do next month.

For my part I would like this Council to reverse the decision made in January, and I would suggest that about half of the sum go to "subsidise" the next Snowflake. This would make next year cheaper and is I think the only realistic way we can reimburse regular Snowflake customers. Perhaps the rest of the money could sponsor some event in Freshers or Charities week at which we would normally expect to either lose or make no surplus. Whether this idea or a much better one will be implemented is up to the next Clubs' Union Council meeting.

If Robert has any suggestions about what we should do about our "problem" of the surplus I should be glad to receive them, and in particular if he would like to participate in the organisation of the next Snowflake Ball, he will be more than welcome.

Yours faithfully,

CHAS NEWSTEAD
(President,
Guy's Hospital Clubs' Union)

Boland House,
Guy's Hospital,
SE1 9RT.

Orchard-Lisle Swimming Pool

Sirs,

I am writing to complain about the disgusting state that the Orchard-Lisle Pool is in. As a regular user I have noticed a distinct drop in the standards of maintenance over the last three-four months.

(1) The whole of the pool surrounds, of supposedly honey-coloured tiles is now covered in a grey-black grime. This is so thick, where the water laps against the sides; that it can be scraped off by a finger-nail.

(2) Not to mention the vast selection of "Elastoplasts"! (I admit people going swimming with these germ-ridden things aren't very hygiene conscious). The maximum number recorded by another regular, was fifteen near the shallow end. These only lasted for a few days; however two plasters managed to stick around for two months! One is into its ninth week (shallow end steps, far side—it could still be there!).

(3) The foot-bath should encourage a high standard of long-jumping if nothing else. Apart from a sediment and grime, plasters, plaster wrappings—one of the hospital consultants (another regular swimmer), spotted a piece of cotton wool with a rather purulent blood stain (shame on the owner, I agree), but even this wasn't removed particularly quickly.

(4) Around the changing rooms and showers a multitude of multicoloured tissues, paper towels and matted hair are the items to be found, plus of course plasters! The largest clumps of matted hair lay around the dryers (which are covered in dust). These can be seen in their nomadic existence, aimlessly drifting from wall to wall.

(5) The door to the office (or is it a coffee bar, launderette, disco?) is covered in black grime—this sums up the standard of the rest of the pool.

Several other users now do "Elastoplast" counts and look at the nine-week survivor — perhaps a sticking power superior to the rest, definitely waterproof!

Considering this pool is not frequented on anything like the scale of the public baths it should be easily kept clean by the multitude of personnel in the office. It makes you wonder what organisms the pathology department could culture from our "hospital pool"!

S. COLE
Dental Dept.
L.C. Area Health.

Don't drink, play hockey and drive!

Sirs,

I have always enjoyed the sports account in the *Gazette* but I was surprised to read this at the end of a cricket account on May 26th, 1979 ". . . was seen staggering towards his car at 9.30 looking as usual unfit to drive his car". I am not concerned with the legal implications of suggesting that the student has broken the law but the lighthearted way in which the inebriated activities of a few students are described. I have all too often seen the tragedy which may befall an alcoholic doctor or of accidents caused by drinking and driving.

Please continue to describe Guy's sports in a humorous way but may that humour not be supplied from the description of alcoholic excess.

Yours sincerely,

J. V. V. LEWIS

Bridge House,
2 Ely Street,
Stratford-Upon-Avon,
CV37 6LR.

Sport

This past month has seen Guy's sport somewhat in the ascendant. The ladies won the U.H. Swimming Gala, whilst on the male side the water polo team narrowly lost in the U.H. Cup Final. The men's first tennis team have also been winning, and have come first in the Inter-Hospital's League. Their captain, Andy Morgan, however, doesn't seem to appreciate some members of the team who turn up at short notice. The cricket team although not keeping their 100% record still maintain their notable standards of this season due in some part to good team spirit. Charlie Tunnadine writes this month's reports in place of Alex "Nickname" Williams. It's good to see some rivalry in writing the reports—a thankless task at the best of times. Many thanks to all contributors!

Guy's on the pitches and courts and in the swimming pools seem to be enjoying success, although somebody seems to have misplaced the Athletics Club. A couple of seasons ago Guy's only narrowly lost the U.H. Cup, however this

season someone must have stolen the club because there remains no trace of it at all.

In response to the mountains of correspondence (mountains? — Phil, O.K. small pile of one letter—Gary) concerning the whereabouts of Sally's dog Sibelius (Hockey report, March issue), I was able to ascertain that Sibelius has indeed returned to Sally's loving arms. Not, however, without a great deal of anguish and trouble on Sally's part. Shame on you Chelsea!

Various news items have come my way over the past few weeks. The Girl's Hockey Club A.G.M. was held recently, Sally Clarke being elected captain. The evening apparently ended in a drunken bawdy joke-telling session! Disgusting, don't know what the world's coming to —after all the Male Hockey Club A.G.M. held the same evening wouldn't have ended like that—would it? Dave Hett was re-elected as next season's hockey captain and informs me that through "friendships" formed at the Folkestone Festival they have been invited to a hockey festival in Italy around September. Well done team! This will be the second Guy's team to tour the Continent this year and must bode well for the future of Guy's sport.

You read it here first . . .

As predicted last month Phil and Ade, the belligerent, bearded, dynamic duo of *Guy's Gazette* cut out one of last month's articles from your sports pages. Even after being referred to (by them, last month) as a dodo I would like to point out that I am not quite extinct (yet). If they haven't cut me out completely I'll see you all next month. Forward all Guy's men and ladies to greater sporting achievements (and if Andy wants me to play again he'll have to ask me nicely).

Oh, and Kristin Pagano is still spelling her name the same as last month.

G. D. C.

Blues

At the Blues Committee meeting held on Monday, 21st May, 1979, the following awards were made.

M. C. E. Hutchinson
(Hon. Sec., Blues Committee)

Rugby Football Club

Mr. Jon Beard—Full Blue.

Mr. Garry Manning, Mr. Huw Williams—Half Blues.

Swimming Club

Mr. Gabriel Teo, Mr. Mark Vella—Half Blues.

Badminton Club

Mr. Les Brann, Miss Diane Christopher—Full Blues.

Mr. Paul Downes, Mr. Colin Hopper, Miss Melanie Newport—Half Blues.

Boat Club

Mr. Graham Cook, Mr. Mark Gaffney, Mr. William van't Hoff, Mr. Andy Wood—Half Blues.

Fencing Club

Mr. Richard Browne, Mr. Richard Loukota—Half Blues.

Football Club

Mr. Andrew Mitchell—Full Blue.

Mr. Mark Batterbury, Mr. Robin Evans, Mr. Steve Robinson, Mr. David Smalley—Half Blues.

Men's Hockey Club

Mr. Duncan Jones, Mr. Richard Plowman, Mr. Gareth Saward—Half Blues.

Ladies' Hockey Club

Miss Julie Sanderson—Full Blue.

Miss Cathy Irwin, Miss Kristin Pagano, Miss Deborah Uwins—Half Blues.

SPORTS FESTIVAL

Once again Guy's were fortunate in picking one of the few fine days of the year for their Summer Festival. The result was a great day for all, sunburn for some and hangovers for many.

The bar was open from nearly the start of the festival, sales increasing logarithmically as teams were knocked out from the various sports.

The tennis tournament started at 11.00 a.m. and finished at 7.00 p.m. This great organisational feat was performed by Andy Morgan (see his report in the Tennis section). The final was won by Tim Thurston and Ann Kerslake who defeated Con Vincini and Clare Keyte. (One small point Andy—in a mixed doubles tournament how come 33 men and 31 girls took part? I know that there are some strange people at Guy's these days but that's ridiculous.)

Two 5-a-side tournaments took place, one for the men and one for the ladies. The men's tournament began at 11 a.m. and finished with the final at 6.30 p.m. Dave Greenaway organised both tournaments in his own inimitable fashion and Simon Perkins looked harassed as usual. The names of the teams were as ingenious as in previous years. In the semi-

finals The Surprised Sperm Whale defeated Dynamo Bermondsey 1—0 after a penalty competition, whilst in the other semi-final Twomey's Tossers defeated the Peace and Harmony Death Squad in controversial circumstances, Mick Corlett afterwards making inquiries into the referee's parentage. The final took place, therefore, between the Surprised Sperm Whale and Twomey's Tossers and produced a worthy culmination of the tournament. The Sperm Whale won 1—0 with a fine goal by Paul Shepherd although John Pascoe hit the bar with an excellent shot, shortly before the final whistle. The referee controlled this match well although somewhat distracted by the chanting of the Peace and Harmony Death Squad. All the matches were played in fine spirit although hotly contested (I've got the bruises to prove it).

The ladies tournament comprised eight teams organised on a knockout basis.

The It's a Knockout tournament involved various entertaining games such as Egg Throwing, Beer/Sack Relay Race, Rugby Ball Dribbling.

The events went on throughout the afternoon providing glorious moments for participants and spectators alike, especially the egg throwing competition organised by the original egg-head Dr. Tamar. Various misdirected high and low flying eggs causing many spectators to move faster than they have done for some years. The competition was finally won by Satan's Beagles (making up for their early exit from the 5-a-side) consisting of Keith and Trevor Underwood, Mike Breeze, Alex Williams and Robin Evans. The prizes (all liquid) were consumed in world record time.

The Tug of War provided many interesting sights helped by the addition of the remaining eggs from the It's a Knockout competition. Mr. Bompas, the Medical School Secretary, took an active part as cheer leader for one of the teams. Dr. Mike Hutchinson refereed admirably, every victory being signified, by a shot from a starting pistol until thankfully for everyone's nerves and eardrums he ran out of cartridges. The Rugby Club (who else) defeated the Gonadic Grapplers in the final, overwhelming them with their superior weight (that's what Gareth Parry must have been training for!).

Last but not least many thanks to Eric and Joyce Dann, Dr. Hutchinson, Dr. Tamar and of course the innumerable organising students who made this a day to remember.

The evening continued with disco, band and free flowing ethanol—but that's another story but I'm assured it's a night John Rawcliffe and Andy Mitchell will want to remember first, and then forget.

Revlac

CRICKET

First Eleven

Our illustrious 1st XI's remarkable run of success has continued with only a few minor hiccoughs along the way—namely one loss, and two draws. At present our record stands at seven wins and one loss out of ten games—which, considering the difficulty one experiences in raising sides, is an extremely meritorious performance.

v. Stoics—lost by 21 runs

This is always an enjoyable fixture, this year being no exception: the Stoics are one of the better roving sides and usually provide a few surprises. Their secret weapon on this occasion was an 8 foot Australian who, on a dead pitch was rarely troubled, except by the admirably dogged Alex "Alex" Williams, who had him dropped twice in three balls off ridiculously easy chances by two players who shall remain nameless (Paul Shepherd and Mick Powell). However, Alex "Big Bob" Williams had his persistence and accuracy rewarded with figures of 5 for 91—not at all bad in the circumstances.

The Guy's reply to their 178 for 6 was tentative, to say the least (or most), being at one stage 73 for 8 wickets. The blame for this may possibly be attributed to overmodesty on the captain's part, who put himself in at number 7. He enjoyed himself however, and with two overs to go we needed only 24 to win. Unfortunately our resistance gave out and he finished with 62 not out, and a lesson learned. The other performance worthy of note was a stoical 27 by John North. (157 all out.)

v. St. Bart's—match drawn

The captain displayed his remarkable organisational ability by turning up with only 10 players to this traditionally bitchy match. However, Mark Powlson heroically saved the situation by answering the clarion call four hours after the start. The game began in good spirits and continued to be so until the last ball before lunch, when our umpire did not uphold, and our batsman did not walk, for a "snick" to the keeper which deafened most of our players in the pavilion. At this point we were fairing rather poorly,

but with this controversy to spur him, Alasdair Jades provided a fine display with a knock of 105 for 8 (eight dropped catches) not out. We declared at 237 for 8, with Tunnadine and Fellows-Smith getting 34 each.

Our fielding display was extremely impressive, including the most spectacular dropped catch of the season by the Leaping Cougar himself, Mark Powlson. We nearly got the wicket anyway, when the bails at both ends rocked precipitously as his massive bulk crashed like an expiring dinosaur onto the grass. The bowling of Alex Williams (2—51 off 17) and the great Dave Hett (2—56 off 17) may be remarked upon, but not here. In spite of some very generous bowling, we could not tempt them quite enough, and they finished at 211 for 6.

v. St. Lawrence, Highland Court

This is Guy's only permanent away fixture, down in Canterbury, and the opposition is always strong. This year the game began late due to an indiscretion on Dave Hett's part. Eventually we started, having located the stumps in the fog. The wicket was docile, so we were not overjoyed to see their opener dropped twice before scoring 5 runs—he eventually made 80, and their total was 223 for 4. Nobody on Guy's side distinguished themselves particularly, except for some athletic fielding by the greatest Dave Hett (athletic?) and John Rees.

We began batting promisingly, but seemed determined to throw our wickets away. However, John Rees, in his first game for Guy's this season, made a lively 47, before being given out, rather dubiously, stumped. After that we had little or no chance of winning, in spite of a critical 49 not out (including no runs off 4 full-tosses in the last over) by the very cautious Andy Mitchell. Our total was a rather lucky 158 for 9.

(P.S. Thank you, St. L.H.C. for your superb hospitality.)

v. Charing Cross Hospital (U.L. Cup)—won by one wicket

This game was most notable for its umpiring, and an exciting finish. In this game the captain won his first toss of the season (and only, so far) and elected to field. This proved to be a reasonable decision, when we limited them to 104 for 9 off 40 overs. Tunnadine and "Williams" both bowled well, taking 4 and 3 wickets respectively for 18 runs each off their 10 overs. Mitchell and Rawcliffe bowled interestingly for a wicket each, and few runs were give away. Their umpire (and captain) gave two interesting decisions—a "wide" off Mitchell, from a full toss which missed off stump by a foot, and ignored a run out, which left the batsman stranded by at least two feet. This amazing display inspired some equally interesting umpiring by our own men. Mention should be made of Alex "I haven't dropped a catch all season" Williams—he dropped three; and a rather fine catch by Mick Corlett (swinging low, swinging free)—who leapt at least thirty feet to his right to a blistering drive and snatched the white hot sphere from the jaws of oblivion, making Peter Shilton look as though his feet are nailed to the goalpost.

James Smith was unlucky to be given out to a l.b.w. appeal, but soon made up for it in his rôle as umpire, giving both his captain (always a bad move) and the next man out l.b.w. to equivocal appeals. Ian Leonard made up for this by giving a wide to a ball which struck our batsman on the pads an inch outside leg-stump—for persistent leg side bowling. Fine decision. Things looked bad, but a useful stand of 57 between Williams (19) and North (39), plus a fine 18 not out from Ollie Penny put the game within our grasp. From the last two overs we needed 10 runs to win—with their best bowler last. However we took 7 from the second last, plus two wides, leaving 1 run to win with three wickets left (having lost Liam Broughton last ball of that over). Easy . . . But John Rawcliffe got out, so Seb Johnston went in, three balls left, one run to win. If no wicket fell, we win on wickets; if one fell but no score, then we draw; if two fell, no score, we lost. Tense, eh? Anyway Seb calmly guided the second last ball to third slip, by which time, Ollie had passed the wicket keeper, Seb trotted home, and the game was ours. No trouble.

We started to play the same rabble on Thursday the same week, this time in the all-important U.H. Cup, but after much faffing around the game was abandoned —but a win is predicted.

v. Past—won by 7 wickets

This year's best batting display in an enjoyable game against the strong batting (on paper, anyway) of our illustrious forefathers. We bowled and fielded reasonably well on the usual dead H.O.P. wicket, and were fortunate to have restricted the score by lunch to 114 for 5, against some class players. Guy Nield and Bob Goodhert both made 32, but only John Rees—this time as opposition —really got on top, with a chanceless 80,

before holing out to Alex "Where's the ball?" Williams. This was a fielding day for youngsters, with Williams, Johnston, Broughton (L.) and Leonard all taking significant catches. (It would be cruel to mention John North's unbelievable drop.) So we were left with a target of 198. After the early loss of Peter Jolliffe, our resident geriatric, John North and Mike Glover put on exactly 100 for the second wicket, Glover eventually going for an exciting 69: not his normal fluent self, but to us mere mortals, fairly impressive. Jimmy "Hey" Smith then knocked up a lively 23—looking better with every shot, until the last one. I believe by this stage, John North was off the mark, but I shall have to confirm this. With 57 runs required, Tunnadine decided to move things on a little and scored 49 not out off 21 balls bowled to him (me), with John ending up on 33 not out—nothing to be ashamed of. So in the end, a fairly easy victory, but extremely enjoyable nonetheless.

A point in passing—the tea provided that day was the best I've had for a fair while. Keep it up, Joyce. I should also like to point out that we are now in the semi-finals of the L.L. Cup, and hope to do at least as well in the U.H. Cup. So if any of you feel inclined to drop in and give us a little support now and then, we shall do our best to reward your effort with a win or two.

Coming Fixtures

June	22	Charing Cross (U.H. Cup)	A
	23	H.A.C.	A
July	1	Brixton West Indian C.C.	H
	7	Westminster Hospital ...	
	11	King's College Hospital ...	A
	14	Nomads	H
	18	Crofton Park	H
	21	Old Citizens	H

C. Tunnadine

v. LONDON 2nd XI

On the Sunday when we played the London, the intermittent showers made it impossible to decide whether the game was on or off. There was a complete lack of communication between the sides, and it wasn't until 1.30 that we managed to contact them, and they said that the game was on twenty minutes later, thanks to S. Gulamali's notable speed at departing for away matches we were still at Guy's. This was fortunate as their captain rang again to say they didn't really want to play. Finally after yet more debate they were persuaded to sally forth.

After all this the 2nd XI had developed a tender regard for their opposition. Strachan, Bellem and Thomas were noticeably eager to bowl, especially at their captain.

The London eventually took the field. Guy's batted well, scoring 150 (?) before declaring at tea. F. Suleman (42) and M. Bellem (42 n.o.) contributed handsomely to the Guy's score. S. Perkins was unfortunately out l.b.w. early on to a very dubious umpiring decision by a fellow team-mate. Strachan was run out without actually hitting the ball but his agility between wickets brought much amusement.

It was finally the opposition's turn to bat and everybody looked forward to the forthcoming fray. However it was not to be, the weather changed for the worse and after one over, torrential rain ended the match.

The general unpleasantness which had been present throughout the day did not end there. We were charged exorbitently for a very sub-standard tea and **no** jugs of beer were exchanged. Thus ended a most unsatisfactory day. We can only hope that the London treat their other opposition with a little more regard and consideration.

C. Thomas

Guy's 2nd v. Crofton Park

We seemed to be blessed with good weather when the 2nd XI took to the field against the unknown strength of Crofton Park XI.

Guy's won the toss and the captain, S. Gulamali decided to let the opposition bat first. The two opening batsmen were soon at the crease and despite fierce bombardment from A. Strachan from the pavilion end and C. Thomas from the other, displayed the tenacity of Lyle's Golden Syrup. This continued, despite the deploying of two further secret weapons in the shape of F. Hughes and N. Bhuva. Finally, however, a breakthrough came with the dismissal of one of the opening pair with a well taken catch by F. Suleman, off Hughes. Was this beginning of the collapse? Unfortunately, the dismissed batsman was replaced by an M. Richards built in the mould of Clive Lloyd. This player then proceeded in the words of the immortal Thomas to "tonk everything that came his way". Richards scored no less than six sixes with as many fours and, despite being dropped early on, went on to score a handsome 56. His innings was only interrupted by two dogs who saw fit to run onto the pitch almost causing the yet unknown "Dog before wicket". Richards was well bowled by A. Strachan

By tea Crofton Park had the enviable score of 156—5 despite fine efforts by the bowlers. The visitors then declared.

Guy's well refreshed, restarted with G. Manning and F. Suleman opening the batting. Despite some elegant strokes by the opening pair Manning soon fell, followed by Bhuva and Hughes. The gallant captain Gulamali then took the crease. With the obvious intention of rallying the side, he played some solid defensive strokes, but could not resist a full toss from Richards. He was caught, whilst he was still kicking himself for playing such a loose shot. Thomas was the next to fall, hoping to hit a ball for six, his hopes were dashed by the presence of an opposition player between himself and the boundary and by the fact he did not hit the ball as hard as he intended. Bramwell was seen to be a mite apprehensive, but on gaining the crease showed composure and hit out with determination. With the next two batsmen quickly out, Strachan entered the arena. This dynamic duo then proceeded to bat magnificently, scoring 60 runs between them. With the number of overs remaining steadily dwindling Bramwell was out for 34, Keen was last man. Finally, it was the last over; Crofton Park brought on their secret weapon—a wily spinner. With three balls to go till the end, Strachan was bowled for 45 to give a final Guy's total of 138. So, despite magnificent encouragement from a coachload of supporters especially bussed in, Guy's narrowly missed a draw. Thus ended an entertaining and exciting Sunday afternoon.

Team: S. Gulamali, F. Suleman, G. Manning, N. Bhuva, F. Hughes, A. Bramwell, C. Thomas, G. Pigot, P. Keen, R. Shravanamuttu, A. Strachan.

GUY'S RUGBY SEASON 1978–79

The season began well with a fairly good, although not always enthusiastic attendance at pre-season training. The 1st team showed up well early on, beating Bromley and leading Blackheath for three-quarters of the match before going down 10—15 at H.O.P. The forwards were moulding into an efficient unit and the backs used the unaccustomed possession well. However the season began to turn sour when injuries and foreign electives struck in October. Charlie Tunnadine, Tim Palmer and Simon Moore were sidelined for the rest of the season. John Brazier and Steve Mihill also suffered with injuries for several weeks and Jon Beard, Mike Broughton and Graham Francis all went on electives thus depleting the experience in the team completely.

Freshers were thus thrust into the fray too early but acquitted themselves well. Huw Williams, Mike Hackett, Richard Flanagan and Andy Girling played regularly for the 1st team and Jon Evans, Steve Dockworth, Dai Maggs and Steve Kennedy also made valuable contributions (and increased the beer takings at every away game considerably).

It was left to the experienced players to shuffle around and make the best of things. Tony Portelly, Brian Keevil and Inky Neill were virtually always present as well as the evergreen Terry Gibson at hooker. Tim Wilkinson blew hot and cold as usual, with Garry Manning working hard at his game at full back. Charlie Robertson always played a reliable game with the forwards and odd games by Richard Laws, Jeremy Grey and Martin Danford showed how we were missing solid experience.

In the last two months of the season, when we were able to field our strongest side, we won more matches than we lost. This form helped Mike Hackett to take over as top points scorer and Huw Williams as top try scorer, and also renewed confidence for a good campaign next year.

We really ought to do well in the Middlesex Sevens one year and get to Twickenham. This year our cause was not helped by over-indulgence in ethanol the previous night by certain members of the team, but guest player Bob Beavis from Australia helped us to a narrow defeat in the second round.

The 2nd team, when it played, was a useful combination. Richard Moore and Paul Emery strengthening the backs on several occasions. This team could be a very good one to play for in the coming year with new freshers pressing for places.

Richard Dunn and Bob Davies looked after the 3rds who had a reasonable side on most weeks and ended up (if Richard's calculations are to be believed) having a better than 50% record.

It is a shame that there was not enough enthusiasm to produce a 4th team this season, when we have had at least six teams playing every Saturday in the past. We are obviously looking to the new intake to strengthen the club as a whole next year and give back to Guy's its role as a major rugby force in South East England.

Gareth Parry
Captain

Guy's R.F.C. Dinner and A.G.M.

The Annual Ball was a great success

this year, held once more in the Saddle and Sirloin. Tim Palmer and Simon Moore put a lot of effort into the proceedings as did Geoff Piggot and Nick Singer who jumped bail just to be there.

The Club president Mr. T. L. T. Lewis presented the Player of the Year trophy to Terry Gibson, a fitting reward for many years loyal service to the club off and on the field. The evening continued with noisily received plaudits for the freshers' team which reached the Gutteridge Plate final. Many thanks to Eric and Joyce Dann at H.O.P. for their usual heroic efforts helping the season run smoothly.

The evening continued with an abrupt adjournment to Guy's where some keen drinkers turned an empty barrel into Young's special in some mystical way while Bob Long was not in one of his most alert moods. The rest of the rugby club then set to work to turn it back into water (!) as soon as possible.

The A.G.M. had a new and successful format, being held in conjunction with the team photograph. The new officers were elected after much discussion. Brian Keevil elected as Captain and Garry Manning as vice-captain are both to be congratulated and all the new committee members hopefully will help to allay the stormy scenes on the Friday before the match as players are sought in the bar. Mr. T. L. T. Lewis was re-elected as President and the main alteration in club policy was to produce a pre-clinical side, playing regularly at H.O.P. on Wednesday afternoon, to stimulate team spirit as soon as new players join the club.

Good luck to everyone involved in the club next year, with an excellent supporter's club, comprising many prominent Guy's men in the wings I am sure we can improve the Club's performance on the field next year.

WATER POLO

Guy's water polo team kept up their good form this season by reaching the final of the United Hospital's Cup, after having previously won the U.L.U. Cup last November.

The first matches of this tournament were held on the 16th May at St. Mary's Hospital. In the quarter final we were drawn to meet St. Mary's, whom we subsequently beat 4—3 in a more convincing manner than the score itself suggests. The semi-final was played 10 minutes after having finished our first match, and here we were drawn against Royal Free.

None of our players were really match-fit, and so we struggled to win this match. At the end of full time, the score was 3—3 and so the game had to go into extra time, when we managed to get a single but vital goal, through Dave Rickard.

In the other semi-final, Bart's managed to beat their strong rivals, the London Hospital, in a thrilling match which also had to go into extra time.

The final was played on the 18th of May in the pool of the Shell Building in York Street. For this match as for our previous matches we remained without the services of our regular goalkeeper, Jon Beard, and Jon Earnshaw kindly agreed to take over this rather important position at very short notice.

The match itself was a very balanced affair, with Guy's initially taking the lead through Gabriel Teo. Bart's, however, hit back strongly scoring two goals to take a 2—1 lead. Guy's levelled through Ray Vella but Bart's again took the lead to lead 3—2. Gabriel Teo scored his second goal to level the score at 3—3.

The superior fitness of Bart's now began to tell and they managed to score two quick goals in the final session and although Guy's managed to pull one back through Mike Miller, they still could not manage to equalise and finally Bart's ran out winners by five goals to four.

It was a very good effort, however, by all the team and we would like to thank all our supporters who turned up to cheer us on, especially our keen president, Mr. Yates.

Guy's team: Dave Rickard (capt.), Ray Vella, Mark Vella, Gabriel Teo, Mike Miller, Jon Earnshaw, Pete Robinson, Mike Evans, Ray Aquilina, Andy White.

R. V.

TENNIS

The Guy's 1st team has won the Inter-Hospitals League. Kings and Charing Cross failed to produce teams and we comprehensively beat Barts, St. Mary's and the London Hospital. The defeat of St. Mary's was the first for some years and long overdue. We have also reached the semi-finals of the Hospitals' Cup.

The standard of tennis in the friendly matches has not been so impressive as reflected in the defeats at the hands of London House and the Baltic Exchange.

The teams chosen for these games have, however, been deliberately weaker in order to give the likes of Lloyd Denmark, Graeme Smith and even Gary Calver (a very late substitute) the chance to have a good laugh. In any case, the

three-course dinner and unlimited beer provided by the Baltic Exchange Club is more than enough to entice people to play tennis for Guy's.

The Mixed Doubles Tournament, which was held on the Festival Day at H.O.P., was a resounding success. 33 men and 31 girls played in a light-hearted competition with the dark-horse couple of Conn Vincini and Clare Keyte reaching the final. The hobbling gait of Vincini served the purpose of distracting their opponents. Only later, when an X-ray showed a chipped lateral malleolus resulting from a friendly football foul, was the charge of gamesmanship refuted. It made their defeat of Rick Wellington and Sue Berry, winners for the last two years, even more creditable. However, in the final, Tim Thurston and Ann Kerslake were too strong for them, and won comfortably.

Guy's tennis is, at the moment, in the ascendant, so it would be good if more pre-clinical people were willing to play in order to keep the standard up over the next few years.

1st team: T. Thurston, J. Pringle, R. Plowman, R. Wellington, S. Moore, A. Morgan.

Andy Morgan

LADIES' WATER POLO

A Ladies' Water Polo Club has been initiated at Guy's this year as an extension of the Swimming Club. Water Polo is a very enjoyable, although a somewhat strenuous game—an excellent way to keep fit.

There has been a strong and successful men's water polo club at Guy's for many years, and the ladies' swimming club often joined in their training sessions. If there are enough of us these sometimes end with mixed water polo matches which are great fun (!).

We had our first all-ladies match against the London Hospital shortly before Christmas last year. Thus far, we have been very successful, winning all our matches. There is sometimes a problem trying to find other teams to play against although a few other London Hospitals are now following our lead, and forming teams. Our last three matches have all been against the Royal Free Hospital.

The first of these was on the 5th March. Guy's played very well against a somewhat inexperienced Royal Free team and gained a resounding victory of 10—0. Tracey Maunder and Liz Palmer scored most of the goals. We played again on 16th May, this time winning 6—2. The improving strength of the Royal Free team was further illustrated by our most recent match on May 30th when our victory margin was narrowed to 3—1. This was a tough game, the teams being more evenly matched than in the past although three of our better players were absent. The goals were scored by Mary Ganczakowski and Tracey Maunder.

In July of this year the ladies will be accompanying the men on their annual water polo tour of the West Country. This is generally considered to be one of the highlights of the water polo year, and of course it will be even better this year.

Our swimmers and water polo players are Guy's students of many disciplines: Medical, Dental, Physiotherapy and Radiography. If any one is interested in playing water polo or swimming our club nights are Monday and Wednesday in the Orchard Lisle Pool at 6 p.m. All are welcome.

The following ladies have participated in some or all of the above matches: Mary Ganczakowski (captain), Elizabeth Palmer, Tracey Maunder, Sally Brown, Sarah Luetchford, Sally Clark, Carol Chew, Helen Kinsella, Alwon Gardiner, Tina MacFarlane, Caroline Smith.

LADIES SWIMMING

The finals of the U.H. Swimming Gala took place on Friday 18th May at the Shell Building, Waterloo. There were a number of spectators present including the president of U.H. and his wife.

Guy's ladies had a strong team in the finals, although competition from other hospitals was not to be underestimated. Our strongest swimmer Tracey Maunder came first in each of her events, namely Freestyle, Butterfly and Individual Medley. Sally Clark and Sally Brown came second and third respectively in the Backstroke final. Liz Palmer and Mary Ganczakowski similarly came second and third in the Breaststroke final.

Our nearest rivals were the London Hospital but we narrowly managed to beat them with a final score of 60 points, to the London's 57.

Mary Ganczakowski as captain of the winning Guy's team presented the wife of the U.H. president with a bouquet. Disappointingly there was no cup to be presented to us, as the previous winners had not returned it. We were assured that it would be given to us when available.

Ladies' Swimming team: Mary Ganczakowski (captain), Elizabeth Palmer, Tracey Maunder, Sally Brown, Sally Clark, Caroline Smith.

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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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Passim

Getting the Sums Right

The plight of Guy's worsens. Perhaps it would be fair to allow Dr. Gerard Vaughan his hundred days before lamenting the lack of any strategic initiative for the Teaching Hospitals, but in the meantime the policies of his predecessors continue to bite deep into our services and morale. It seems to us that nothing less than full financial and administrative recognition of our national role as centres of education, research and special expertise will deliver us from the painful and false equations of Resource Allocation.

Lewisham, Southwark and Lambeth Area Health Authority is in a steadily deepening financial crisis. Guy's, St. Thomas' and King's College Hospital have been instructed to reduce their budgets in "high cost specialties" while at the same time the Medical Schools have suffered a substantial cutback in their U.G.C. Grants as a result of the recent Budget. The A.H.A. fought a long battle with the previous Government about spending cuts, and so acrimonious did the dispute become that the former Health Secretary David Ennals gave the authority the choice of cutting back or being replaced by an alternative body.

In the absence of any initiative from the new Government, cuts are being enforced which will take £4 million off an annual spending budget of £129 million. Rightly or wrongly, the A.H.A. refused to sanction cuts in general services to patients, concentrating them instead on such specialties as kidney dialysis and transplants, the King's Liver Unit and open heart surgery. It is hoped that in this way local people will get the better deal, for the high cost, high technology specialties serve patients from all over the country. This move should not surprise us coming at a time when Westminster Children's Hospital's bone marrow unit faces closure for want of £24,000.

That the Health Service as a whole will suffer as a result of these misguided levelling policies we have no doubt. In recent times, as money has become scarcer, some criticism has been directed at the greed of the Teaching Hospitals, as the most favoured institutions of a Health Service in decline. Attention has been drawn to the unhappy historical accident whereby Guy's, St. Thomas' and King's find themselves uneasily close neighbours; each national institutions in their own right, each fighting for smaller and smaller pieces of the local financial cake. Small wonder that such a long-running man of the people as Dr. Cyril Allen should complain that resources are more needed for primary care in the community, or for the Medway towns or South coast—in fact anywhere except for that collection of ivory tower-blocks in London, where scientists and administrators engage in esoteric practices of little relevance to local people in need.

We would dispute this, but nonetheless our special status is clear. Perhaps it is time that our A.H.A. were replaced by an alternative body, one which recognises the national contribution of the major Teaching Hospitals. Whichever way you look at them the present sums are wrong.

The Merrison Report

The Royal Commission on the National Health Service, under the chairmanship of Sir Alec Merrison, has finally made its recommendations—over three years since its formation in 1976. Its terms of reference were *"To consider in the interests both of the patients and of those who work in the NHS the best use and management of the financial and manpower resources of the service."* To this end it has made some 117 proposals.

Considerable amounts of time, effort, and money (just under £1 million) have been put into the making of this report, and it is, therefore, disappointing that many of its proposals are unoriginal—although this is probably inevitable with so prolonged an investigation. These are still valuable, however, since some of them are very sound—such as the need for cutting administration, which the report suggests could be effected by amalgamation of area and district levels—although its proposals for greater regional autonomy may lead to less flexibility.

Other proposals are rather more contentious, and it has been suggested that these seem to reflect the views of the previous administration who set up the Commission. For example, the report criticises the contracts for hospital doctors, especially separate payment for work 'outside office hours.' It also suggests that GPs should be salaried employees, not independent contractors. It does not conclude that the private sector is beneficial or detrimentary to the NHS, but it does recommend that the Health Services Board be empowered to control the total number of beds in private hospitals and nursing homes when any new private development is considered. It also recommends that new procedures should be developed for dealing with pay disputes, and that the TUC should initiate talks towards this end.

The most serious defect of the report, however, is that while it would require more money to be spent on the NHS, it does not suggest any way to obtain this, other by direct grant taxation revenue by the Exchequer. Indeed, in this respect the Commission could be accused of failing their brief—in that their proposals would require more money than would be obtained by their suggested cuts and by growth in the economy while keeping the percentage of the GNP allocated to the NHS constant. It argues a convincing case against the use of an insurance-based system to finance the NHS, which has been proposed by some Tories, but fails to discuss other possible sources of revenue.

Despite its inadequacies, the report should not be summarily dismissed. The Government should seriously examine some of its comments when drawing up their own autumn proposals for the reorganisation and simplification of NHS administration. Furthermore, it is now time for all political parties to consider the ethical responsibility of making continual changes in NHS strategy for merely ideological ends, since these affect medical care, and will continually change with alterations of Government, leading to an increase in uncertainty and friction, and to a decrease in efficiency and standards. The report says that *"There is no need to feel ashamed of our health service and there are many aspects of it of which we can be justly proud."* True enough, but it can still be considerably improved—as long as changes in NHS policy have medical as well as financial justifications, and are not merely convenient for doctrinaire politicians or empire-building bureaucrats.

News in Brief

The Birthday Honours List

We are pleased to announce that Professor Dinah James who is working in the Pharmacology department at Guy's, was awarded an O.B.E. for services to medical education, in the Queen's Birthday Honours List. We offer her our warmest congratulations.

Dr. Adrian Caro

We are delighted to hear that Dr. Adrian Caro (Guy's 1970) has received the top award for research made by the medical newspaper *Doctor*. Dr. Caro who had to overcome the problems of dyslexia, received the award for a thesis on Huntingdon's chorea.

Because of his reading and spelling difficulties Dr. Caro had some difficulty obtaining a place at a medical school. More than 40 applications failed to produce one interview and we are proud to say that he succeeded in gaining a place at Guy's.

Dr. Richard H. Greenwood

Our congratulations to Dr. Richard H. Greenwood (Guy's 1968), Lecturer in Medicine at the Welsh National School of Medicine, who has been appointed Consultant Physician with an interest in Diabetes and Endocrinology to the Norfolk and Norwich Hospital in Norwich.

New clinical introductory course

Clinical students on their medical and surgical firms this September are asked to assist new clinical students joining the firms in a one week overlap period from September 24th. In that week the new students will be "apprenticed" to their senior colleagues, though not attending ward rounds and outpatient clinics. The aim of the one week course is to smooth the transition from the BMS years to clinical studies. During it the new students will inherit the patients on each firm, learn practical procedures and the nuances of ward routine and undertake a day and a night shift of nursing on their wards. The cooperation of the senior students will largely determine whether this experiment is a success.

Guy's Cross Channel Sail

On their second attempt, the Sailing Club succeeded in crossing the Channel in three dinghies on July 13th, escorted by a sailing yacht also crewed by Guy's students. The sponsored sail was undertaken to raise money for a new dinghy and for the R.N.L.I. A full report will be published in the Autumn.

No August issue

The Editors regret that again this year there will be no August issue, and our next issue will be a special freshers number in September. The next copy date is September 17th 1979. Please note that our office will be closed for business between 20th and 26th August.

Guy's houseman wins road race

A well-known Guy's houseman accompanied by a staff nurse from New Cross recently drove to victory in a privately organised race from London to John O'Groats. The Death Race 2000, as it was called, had been publicised in the *Hickey* column in the *Daily Express* and amongst the twenty starters were several well-known members of Society. There were two check in points at King's Lynn and Gainsborough and the race was won in 11¼ hours.

We congratulate our budding racing driver for showing once again that if called upon a Guy's man is more than equal to his fellows!

Vouchers for the Royal Academy

We still have a few vouchers enabling students to obtain admission to the Summer Exhibition at the Royal Academy of Arts at a reduced rate. These free vouchers can be obtained from the *Gazette* office on Mondays, Tuesdays and Thursdays.

Dr. Carl Westman

We regret to announce that Dr. Carl Westman, late of Ostermalmsgatan 94, Stockholm, Sweden, died on June 11th at the age of 95. Dr. Westman qualified at Guy's in 1915 and had been a regular subscriber since then. Two years ago he wrote an article for the *Gazette* ("In the old days at Guy's") which gave a fascinating insight into hospital life in the First World War. We pass on our sincere condolences to his daughter, Mrs. M. Sutton-Pratt.

Dates from the Medical Diary

August

Wed. 1 Entries close for Final M.B., B.S. (Old Regulations) Examinations.

Wed. 8 Entries close for Preliminary Examination for Studies in Medical Subjects.

Fri. 24 Entry forms for M.B., B.S. (Revised Regulations) Examinations in November must be left in the Medical School Office not later than this date.

Mon. 27 BANK HOLIDAY—Medical School Office closed.

Mon. 27 Entries close for final Conjoint Examination in September.

September

Mon. 17 Preliminary Examination for Studies in Medical Subjects may begin.

Mon. 24 Basic Medical Sciences Examinations (Resit) begin.
Final Conjoint Examination begins.

Fri. 28 Entries close for the M.B., B.S. (Revised Regulations) Examinations in November.
Projects for the Richard Ellis and Handicap Essay Prizes must be handed into the Medical School Office by this date.

Dates from the Dental Diary

August

Mon. 6 Applications close for the Final L.D.S. Examination, Part II (Dental Prosthetics).

Wed. 8 Entries close for Preliminary Examination for Studies in Medical Subjects.

Mon. 13 Applications for the first L.D.S. Examination (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date. Applications close for the Final L.D.S. Examination, Parts I and III.

Fri. 17 Entries close for the Final Year Prize Examination.

Mon. 27 BANK HOLIDAY—Medical School Office closed.

Tues. 28 } STUDENTS BEGINNING THE
Wed. 29 } CLINICAL PERIOD OF STUDY
Thur. 30 } COMMENCE WORK

September

Fri. 7 Applications for the Third B.D.S. Examination, Parts I, II, III, IV & V (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Mon. 10 Written Paper for Final Year Prize—this week.

Mon. 10 Final L.D.S. Examination, Part II (Dental Prosthetics) begins.

Wed. 12 N.B. The Preliminary Examination for Studies in Medical subjects will begin this week.

Mon. 17 Applications close for the Final L.D.S. Examination.

Mon. 24 Final L.D.S. Examination Part I begins. Entries close for the Prize in Children's Dentistry, including Orthodontics.

Clubs' Union News

At the last Clubs' Union Council meeting it was decided that half of the surplus made at the last Snowflake Ball would be used to book a name band for a Freshers' Ball to be held on Saturday the sixth of October at the end of Freshers' week. The rest would be ploughed into the next Snowflake. This plan was decided on after considerable discussion. The reason why all the money was not put into the Snowflake was that by subsidising it to a large extent would mean that the people organising it for the year after next would find themselves pricing tickets at about double last year's cost (allowing for inflation). Such a big jump is likely to lead to considerable consumer dissatisfaction and boycotting of the event.

Also at that Council meeting we discussed the farcical situation with regard to the turnout for General Meetings. It was pointed out that the present system was set up about seven years ago, the idea being to ensure greater accountability for the Union Executive. When this constitution was devised it was thought and with hindsight this appears to have been considerably naive that students would be only too pleased to turn up for meetings, even if only to approve matters of business that have to be ratified to allow any sort of smooth running of the Clubs' Union. The feeling at the Council meeting was that this constitution has had a fair run and in order to free ourselves from the "shackles of apathy", to borrow a phrase from our redoubtable junior secretary we would have to change the constitution. In order to achieve this a constitutional sub-committee was set up and I hope it will report within a couple of months. What I would like to see is a reversion to a student representative council with a set number of delegates from each year plus a small number of official posts as at present. There would also be

some members of the staff to provide for the continuity so often lacking in student affairs. This body obviously would have greater powers than at present held by the Clubs' Union Council. There would still be an Annual General Meeting and the mechanism for calling special or emergency general meetings would be simplified. This is a necessary safeguard against irresponsible or incompetent people who could hold posts which will influence your lives.

You may remember that in the April issue of the *Gazette* I wrote a long tirade centred on the Medical School's apparent indifference to the standard of catering provided for students at Guy's. I mentioned that due mainly to my efforts the School were at last scheduled to meet the Hospital Catering Function and discuss some plans that they had been asked to draw up for rationalising and amalgamating the catering at Guy's. This meeting has now been postponed no less than *three times.* As soon as we do co-ordinate this historic confrontation, and it is going to be at least another two weeks yet, I will let you know the outcome and the plans for the next part of the battle.

Mark Powlson has the plans for Freshers' Week well in hand; the Freshers' Fair this year will be held in the evening of Monday, 1st October and the sports trials as usual on Wednesday. This is really a message to all club officials; *"see you there"!* Chas Newstead.

The Fison Memorial Lecture 1979 – A Birth of Logical Positivism – A Tribute to the Vienna Circle

Delivered at Guy's on July 3rd, by Professor Sir Alfred Ayer, M.A., F.B.A.
Chairman: Sir Hedley Atkins, M.Ch., D.M., F.R.C.S.

It is a remarkable privilege to be able to listen to Sir Alfred Ayer on the subject for which he has become renowned in his own lifetime.

He set out to demarcate sense from nonsense in his first book, *Language Truth and Logic,* published in 1936, which he described as being *written with more passion that most philosophers allow themselves to show, at any rate in their published work.*

Although Sir Alfred has abandoned many of the original tenets of his philosophical manifesto, his influence upon philosophy and science has been enormous.

In the lecture he turned his scholarship and charm to the birth and development of the school of philosophy known as logical positivism. Its adherents, who formed the Vienna Circle, consisted mainly of scientists and logicians with the common aim of making philosophy the handmaiden of science. Keep in mind that the period was in the immediate wake of Einstein, Bohr and Planck, and that the success of science was as great as it had ever been.

Sir Alfred originally intended to study with Wittgenstein at Cambridge, but on the advice of his Oxford tutor, Gilbert Ryle, whose father was a Guy's man, he went instead to Vienna and was later invited to join the Circle.

In the lift down after the lecture, however, it rapidly became apparent that even Sir Alfred had found it difficult to compress so complex

a matter into the brief time available, such that it was clearly understood by all. It was suggested therefore, that the *Gazette* might publish an introductory account of logical positivism by a graduate in Philosophy.

Logical Positivism –

an explanation by John Pini

"The traditional disputes of philosophers are, for the most part, as unwarranted as they are unfruitful. The surest way to end them is to establish beyond question what should be the purpose of philosophical enquiry."

Thus wrote A. J. Ayer in Chapter One of his hypnotically readable *"Language, Truth and Logic"*, first published in January 1936, when its author was just twenty-five. The book has become a classic in its own time and remains *the* manifesto of Logical Positivism in British philosophy.

The first school devoted to this "new philosophy", as it was then, met in Vienna in the 1920's and was known as the Vienna Circle. The background was respectably catholic: the leader, Moritz Schlick was a physicist as was another member, Rudolf Carnap. Otto Neurath was something of a polymath but principally a sociologist whilst Kurt Gödel, another member, made valuable contributions to the study of formal logic. To this group came the youthful Ayer, and the equally youthful and now equally famous American logician, Willard van Orman Quine.

The movement was characterised by an uncompromising criticism of the metaphysical idea that philosophy can give us knowledge of a reality over and above the world of science and common-sense. They regarded metaphysics, in so far as it tried to speak of a world more "real" than that of every-day experience, as an activity to be ashamed of: the metaphysician was a purveyor of "news from nowhere". As early as the 18th century, British philosophy displayed a similar hostility to these fantasy-peddlers, a hostility well expressed in a famous passage by the Scot, David Hume (1711–1776):

"If we take in our hand any volume of divinity or school metaphysics let us ask: does it contain any abstract reasoning concerning quantity or number? No. Does it contain any experimental reasoning concerning matter of fact and existence? No. Commit it then to the flames for it can contain nothing but sophistry and illusion."

This rallying cry, with its doubts about the status of metaphysical propositions, was later to be expressed, albeit in more sober style, by one of the circle, Carnap, in his book "The Logical Syntax of Language" first published in 1937.

"The suppositious sentences of metaphysics, of the philosophy of values, ethics . . . are pseudo-sentences, they have no logical content, but are only expressions of feeling."

The attitude then of the Circle to metaphysicians was similar to the attitude today of medical practitioners to witch-doctors: merchants of harmful obscurantism. Broadly speaking this was the stance of the Vienna Circle, but stating *what* they believed will not help us to understand *why* they believed it.

A simple answer, but not I think an over-simple one, is the impact

Sir Alfred Ayer

Sketch by Ken Chen

of science, an impact so great that it led the philosopher Bertrand Russell to exclaim ". . . *to think I've spent my life on muck.*" The birth and ascendancy of nuclear physics, with its seemingly preposterous idea that even solid objects were composed of particles in motion, created difficulties for a philosophical analysis of such traditional concepts as matter and substance. Not only philosophical difficulties ensued since these scientific advances tended to violate and do injustice to our ordinary common-sense intuitions about what the world was like. Very rapidly large areas of knowledge were swallowed up by the scientists, leaving the philosophers to utter only the speculative assertions the Positivists so abhorred. There was then a healthy respect for science and a concomitant feeling, frequently voiced by Russell, that philosophy ought to be more scientific, or at least more rigorous in its outlook. The tool for this new analytic approach was supplied by the pioneering work of the German mathematician Gottlob Frege and by Russell and A. N. Whitehead in their monumental *"Principia Mathematica":*—a highly sophisticated logic of relations. As Ayer explained recently in a televised discussion with Bryan Magee:

"The Logical Positivists saw both Einstein's work in the Theory of Relativity and also the new Quantum Theory as vindications of their approach, because what Einstein had done was to say that you cannot attach sense to a concept like simultaneity unless you consider how statements about simultaneity are verified. That is to say, what is **meant** *by talk of things being simultaneous depends on how simultaneity is determined in observation."*

The Positivists took this as proof that what scientific concepts mean is the way they are verified and they accordingly sought to arrive at a criterion of *meaning* that science would pass and metaphysics would fail. This central criterion, around which nearly all of the literature of the subject revolves, was called the Principle of Verification and the classic statement of it was given by Schlick:

"The meaning of a proposition is the method of its verification."

There were two ways in which a statement could satisfy this criterion, a criterion which to this day has never received a satisfactory formulation. The first was if the statement could be verified, or tested, by making observations, by submitting the statement to the tribunal of sense-experience. Ayer allowed for two senses of "verify". He wrote that *"a proposition is said to be verifiable, in the strong sense of the term, if its truth could be conclusively established in experience. But it is verifiable in the weak sense if it is possible for experience to render it probable"*. All statements that could *not* be verified in this way, or empirically as it was called, were condemned as *"literally meaningless"*.

Some statements however might not be verifiable in this way and yet still be admissable. These statements were called tautologies, or what Immanuel Kant had earlier called "analytic", and the Positivists derived this part of their doctrine largely from Ludwig Wittgenstein's book *"Tractatus Logico-Philosophicus"*, first published in 1921. A tautological statement was one where the right-hand side of the statement was merely a repetition of, or unpacking of, what the left hand side had already said. Examples would be, "All bachelors are unmarried men" or "All triangles have interior angles adding up to 180°". To check whether these types of statement are true you do not do a field-study of bachelors or triangles but simply reflect on what the words mean. Further,

tautologies are said to be empty of content in that they tell you nothing about the world.

We have then two types of admissable statement:

1. Empirical statements—where observations determine truth or falsity.
2. Tautological statements—where word-meaning determines truth or falsity.

Having produced a criterion of significance it was then easy to say that the metaphysician *"produces sentences which fail to conform to the conditions under which alone a sentence can be literally significant"* (Ayer). Any statement that failed to respond favourably to these tests, like a metaphysical statement, was dismissed as being literally senseless.

These rules were rapidly learnt and achieved the status of a party-game amongst undergraduates of the thirties. Victims were liable to be pinned to the wall, notes Bryan Magee, with a searching *"How would you verify that assertion?"* However the Principle of Verification, at least in its strong form, possessed a plausibility that bore little critical inspection even to its advocates.

As well as demolishing metaphysics, which was intentional, the unintentional and unwelcome result was that historical statements, since unverifiable, were also illegitimate. Psychological statements about feelings succumbed since only behaviour was observable and, as might be expected, statements about religion fared disastrously. But perhaps the most telling objection was the status of the principle itself. Was it verifiable by observations or was it tautologous and hence empty of content? Neither possibility looked promising. On his last attempt to formulate the principle successfully Ayer was, as he put it, "torpedoed" by the American logician Alonzo Church.

Despite these grave internal difficulties Logical Positivism has virtually transformed our conception of philosophy. From its original "first-order" activity of constructing theories about the world, as the great architects of the 17th century did, philosophy is now seen as a "second-order" activity, criticizing concepts to make their boundaries sharper. These concepts that it scrutinizes may be scientific (probability, induction, confirmation), psychological (intention, will) and many others. There was then a very natural slide from Logical Positivism to the linguistic philosophy as practised in Anglo-American universities today and for this A. J. Ayer bears both responsibility and credit.

Ludwig Wittgenstein and Guy's Hospital

by J. R. Henderson

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Hospital porters are not, as a rule, a group of people noted for their intellectual achievements. So it is a matter of interest when the man who is Professor of Philosophy at Cambridge, and probably the most influential philosopher of his time, becomes a hospital porter. Ludwig Wittgenstein came in this way to work at Guy's in 1941, and this article

is an attempt to outline the life of this extraordinary man, and to concentrate particularly on the two or three years in which he was associated with the hospital. It does not attempt to explain his philosophical ideas.

Wittgenstein was born in Vienna in 1889, the eighth and last child of a wealthy industrialist. His family were originally Jewish, though Wittgenstein was baptized a Catholic, a fact which may or may not be relevant. The household was a richly musical one, Brahms being a close family friend; Paul Wittgenstein, one of Ludwig's four brothers, became a distinguished concert pianist and, after the loss of his right arm in the first world war, continued to play with his left. Ravel and Britten both wrote concertos for left hand and orchestra for him. There is no record of whether the Wittgenstein household was a happy one, though, as three of the brothers subsequently committed suicide, something must have been awry somewhere.

Ludwig was educated at home until he was fourteen; he was fascinated by machinery, and is said as a boy to have made a sewing-machine that was much admired. His higher education was, predictably enough, in engineering, at the Technische-Hochschule in Berlin-Charlottenberg. In 1908, when he was nineteen, he came to Manchester University to be a research student in the department of engineering, where his interests were in aeronautics and he was concerned with the design of something called the Jet Reaction Propeller. He was at this time deeply unsure of himself as a person and of his future. In his three years at Manchester his interests moved from engineering, via the mathematical problems of propeller design, to the philosophical basis of mathematics. Lonely and withdrawn, he somehow managed to establish a rapport with Frege, the German mathematical philosopher, and visited Frege in Jena several times during his stay in Manchester. Frege, appreciating his talent, advised Wittgenstein to study logic and mathematics with Bertrand Russell at Cambridge, and he moved to Trinity College, Cambridge in the autumn of 1911.

Russell was, even at that time, an institution, a doyen of English mathematical philosophy. But Wittgenstein did not take to Cambridge; he hated any sort of insincerity, small talk or pretentiousness, and this presumably cut him off from a large number of university activities. He would visit Russell's room at night and pace up and down for hours on end in agitated silence. Russell writes in his autobiography (volume 2, p. 99): "At the end of his (Wittgenstein's) first term at Trinity he came to me and said 'Do you think I am an absolute idiot?', I said, 'why do you want to know?'. He replied, 'because if I am I shall become an aeronaut, but if I am not I shall become a philosopher'. I said to him, 'my dear fellow, I don't know whether you are an absolute idiot or not, but if you will write me an essay during the vacation on any philosophical topic that interests you, I will read it and tell you'. He did so and brought it to me. As soon as I read the first sentence, I became persuaded that he was a man of genius, and I assured him that he should on no account become an aeronaut." (Many of Russell's anecdotes have this slightly too-good-to-be-true quality about them.) Later Russell writes: "Wittgenstein was perhaps the most perfect example of genius as traditionally conceived; passionate, profound, intense and dominating. He had a kind of purity which I have never known equalled except by G. E. Moore." (Wittgenstein subsequently succeeded Moore as Professor of Philosophy

at Cambridge.) Shortly after he arrived at Cambridge Wittgenstein's father died, leaving him a large fortune which he later gave away.

In 1913 Wittgenstein left Cambridge, because (according to Russell) his brother-in-law was coming to live in London, and Wittgenstein could not bear to be so near his brother-in-law. Even by Wittgenstein's standards this was a remarkable reason. He built himself a hut on a Norwegian farm and lived there for two years, filling notebooks with his thoughts and corresponding with Russell. His isolation was interrupted by the outbreak of the first world war, and he became an officer in the Austrian army.

As a trained engineer he presumably was of great potential use to the army; but as a man relating to his fellow soldiers, he might well have been a disaster. Ironically it was during this period, which he spent mostly in the trenches, that he wrote the one book published in his lifetime, and the work that made him famous. It is the *Tractatus Logico-Philosophicus;* it is a daunting title for a daunting book. More will be said of it later. Russell wrote the preface, and characteristically Wittgenstein disapproved of what he wrote—throughout his life he asserted that people invariably misunderstood him. He was actually taken prisoner by the Italians *after* the armistice of 1918, apparently because the Italians, for face-saving reasons, wanted to have as many prisoners as possible to return. J. M. (later Lord) Keynes organized his extrication from the prison camp.

It is said at this time that Wittgenstein, in writing the *Tractatus* felt that he had solved all the problems of philosophy, and he spent two years in Vienna on a course learning to be an elementary school teacher. For the next four years he taught at village schools in southern Austria, mostly at a village called Trattenbach. This part of his life has been documented in detail in a recent American biography (*Wittgenstein,* by William Warner Bartley). Bartley claims that Wittgenstein was at this time a homosexual "given to bouts of extravagent and almost uncontrollable promiscuity" and his evidence for this is based on many interviews with the habitués of homosexual bars in Vienna that Wittgenstein used to frequent. If Bartley's assertions are true, Wittgenstein's desire to be a school teacher can be interpreted in a sad light. The Austrian peasants did not take to him—according to Russell, they refused to sell him milk because Wittgenstein did not teach their children sums about money. In 1926 a court case was brought against him in which he was accused of cruelty against the children. Although he was acquitted, it was the end of his career as a school teacher. If Wittgenstein remained a practising homosexual for the rest of his life, it is remarkable that none of the biographical accounts have seen fit to mention it, but of course the omission may have been, out of delicacy, deliberate. If the assertion were true, then a great deal of the mental anguish that he suffered throughout his life could be explained.

His sister lived in Vienna and asked Wittgenstein to design a house for her and supervise its building. He threw himself into the job for 2 years and produced (in the words of G. H. Von Wright) "a house free of all decoration, and marked by a severe exactitude in measure and proportion. Its beauty is of the same simple and static kind that belongs to the sentences of the *Tractatus.*" In this period Wittgenstein also did some sculpture. Von Wright remarks on this: "There is a striking contrast

Ludwig Wittgenstein

Sketch by Ken Chen

between the restlessness, the continual searching and changing in Wittgenstein's life and personality, and the perfection and elegance of his finished sculpture."

He returned to Cambridge as a philosopher in 1929, and, as the author of the *Tractatus,* a person of importance. He was made a fellow of Trinity College in 1930, and throughout the thirties developed a new philosophy which involved rejecting many of the ideas of the *Tractatus.* His teaching and research were intertwined. He did not give lectures, but invited to his room those students who were intellectually tough enough to come. There was no furniture or decoration in his room, only a card table, a bed and a number of deck chairs which were usually kept outside the door. Wittgenstein sat in the middle of the room, and according to Norman Malcolm, who attended many of the "lectures": "Here he carried out a visible struggle with his thoughts. He often felt that he was confused, and said so. Frequently, he said things like 'I'm a fool', 'You have a dreadful teacher' . . . there were frequent and prolonged periods of silence, with only an occasional mutter from Wittgenstein, and the stillest attention from the others. During these silences Wittgenstein was extremely tense and active. His gaze was concentrated; his face was alive; his hands made arresting movements; his expression was stern. One knew one was in the presence of extreme seriousness, absorption and force of intellect . . . He was always exhausted by his lectures, often he would rush off to a cinema afterwards. He might look imploringly at a friend and say in a low tone "could you go to a flick?". On the way to the cinema he would buy a bun or a cold pork pie and munch it while he watched the film. He always had to sit in the front row; his favourite film stars at this time were Carmen Miranda and Betty Hutton. Wittgenstein hated academic life in general, and often tried to prevent his students from becoming professional philosophers. He was made Professor of Philosophy at Cambridge in 1939, but war broke out shortly before he took up the chair.

Wittgenstein at Guy's

It is likely that the beginning of the war was actually a relief to Wittgenstein; he could escape from Cambridge and do something to help in a practical sense. Unlike Russell, he was not a pacifist, but as an Austrian with British nationality, it would have been impossible for him to fight for either side. I cannot discover his whereabouts for the first 2 years of the war—all that is clear is that he appeared as a porter in the Guy's dispensary in 1941. Within the context of Wittgenstein's life, this event makes perfectly good sense and the question posed in the first paragraph can be answered. In the dispensary he worked under Mr. R. F. Izzard, and showed a lot of initiative in improving the manufacture of various ointments. Izzard was surprised that a porter should have such an instant grasp of the techniques involved, and he writes that Wittgenstein made the finest quality Zinc Oxide ointment that had been seen in Guy's up to that time. In that period everybody working in Guy's ate together in Nuffield House, and shortly after Wittgenstein's arrival he was enthusiastically greeted at dinner by the hospital haematologist, Dr. R. L. Waterfield. Waterfield was an amateur philosopher, and had seen Wittgenstein at meetings. On being recognized, Wittgenstein turned as white as a sheet, and said, "Good God, don't tell anybody who I am".

One of the few friends that he made at Guy's was a fellow assistant

in the dispensary called Roy Fouracre. Fouracre, who was then in his early twenties, is a friendly, totally genuine man, and these were qualities that meant a great deal to Wittgenstein. Fouracre would visit Wittgenstein in his room on the third floor of Nuffield House. The room was, of course, almost completely bare; Fouracre never saw a philosophy book there, but only neat piles of Westerns which Wittgenstein devoured at a great rate. Fouracre was learning pharmacy and modern languages at the time, and the two men had many conversations about the basis of language. Often Fouracre read while Wittgenstein sat quite still, mute and never writing, for periods up to an hour. During these times he was preparing for his teaching, for on alternate weekends he would go to Cambridge to lecture. On the other weekends he and Fouracre would go on outings, either to the Zoo (Wittgenstein never learnt the name of a single animal on their many visits. He just liked the Zoo), or rowing at Victoria Park Lake, Homerton. The simplicity of moving through water with oars greatly appealed to him.

Wittgenstein was also greatly interested in music (perhaps not surprisingly in view of his family's friendship with Brahms), and the only female acquaintances he had in Guy's were a result of this interest. They included Miss Naomi Wilkinson (a Radiographer), Sister Butler, and a sister of fierce repute known to everybody as Daisy May. Wittgenstein seems to have been genuinely frightened by women, and on one occasion he was admitted to Daisy May's ward for some small but painful operation (it is not clear what it was). At that time he knew Daisy May only as a dragon, and when he came round from the anaesthetic he found her holding his hand. This was the sort of simple act of kindness which touched him deeply. Wittgenstein did not play a musical instrument, but he was a virtuoso whistler; Fouracre recalls how he could whistle whole movements of symphonies. His show piece was the Brahms' "St. Anthony Variations". When other people whistled something wrong, Wittgenstein would stop them and firmly tell them how it should go, which didn't endear him to his fellow workers in the dispensary. Fouracre left the dispensary at the end of 1943 to join the army, but he continued his friendship with Wittgenstein until Wittgenstein's death in 1951. He actually left Fouracre £100 in his Will; I suspect that this represented a good proportion of his estate.

Also dining in the hospital in the evening at this time were Dr. R. T. Grant and Dr. (now Professor) B. Reeve, who were working on wound shock for the Medical Research Council. The Blitz was presenting them with many of its victims. Grant and Reeve first got to know (if that is the proper word) Wittgenstein over dinner. Grant found him tense and critical, and in conversation no inexactitude of expression was allowed; but Wittgenstein would always throw some new light on whatever subject was raised. The work that Grant and Reeve were doing represented something important to Wittgenstein, for he had, about ten years before, seriously considered giving up philosophy and studying medicine. So when the M.R.C. unit moved from Guy's to the Royal Victoria Infirmary at Newcastle, Wittgenstein went with it as Grant's technician.

The unit consisted of four people: Grant, Reeve, Wittgenstein and Miss Helen Andrews (who was Grant's secretary, and according to Grant, greatly in awe of Wittgenstein). The curious quartet went to live in the Newcastle house of a landlady called Mrs. Moncrieff, spending the days working on shock in the Royal Victoria Infirmary and at the week-

ends going for walks in the surrounding country. Walking with Wittgenstein is a topic which often recurs in accounts of his life; he would indulge in fierce disputations and expect his companions somehow to keep up with his thoughts, and was instantly aware if their concentration wavered. Grant and Reeve found the trips exciting and exhausting. The walks were obviously of the greatest importance to Wittgenstein, for he was preserving in himself the one thing that mattered in his life. In the day time he cut frozen and paraffin sections (which he did very well) and occasionally made use of his engineering skills. On one occasion Grant was investigating the phenomenon of pulsus paradoxus (the diminished pulse pressure seen on inspiration that is usually the result of pericardial effusion) in rats, and Wittgenstein invented a new and improved way of recording pulse pressure. For some reason, the quartet had to leave Mrs. Moncrieff's house, and look for their own separate digs. The others had little difficulty in finding rooms, but Wittgenstein, whose dress was always rather *ad hoc,* knocked on landladies' doors wearing a flat peaked cap and a windcheater. In 1944 the average Newcastle landlady seemed to find this rather disturbing, and it took him several days to get a room.

Later in 1944 the M.R.C. unit became part of the army and Grant and Reeve left Newcastle for Italy to continue their work on wound shock. Having no wish to go to Italy, Wittgenstein stayed in Newcastle, and became technician to Grant's successor, Dr. E. G. Bywaters (even then *managing to lecture at Cambridge). He remained there until the end of* the war, when he returned to Cambridge to take up the chair of Philosophy. But the war had changed nothing: academic life still appalled him, and he resigned the chair in 1947. Here are two letters that Wittgenstein wrote to Fouracre during this period. They are simple and affectionate in tone, and reflect the straightforward friendship that existed between the two men.

Trinity College, Cambridge.
1946.

"Dear Roy,

I had a letter from you this morning, in which you say that you have no hope of coming back this year. I am very sorry to hear this, both for you and for those who are looking forward to seeing you again. Though why in bl . . . anyone should wish to see you back here beats me. You say you haven't heard from me again for some time, but I'm writing pretty regularly. It's the Censor who keeps my letters; and I don't blame him, either, because they're so full of wit and wisdom. It must be difficult for him to read one of them and then let it go again. I'm sure he collects them and one day they'll be published—the weather here is awful and I feel pretty lousy most of the time. My lectures are going well, so far. What I miss most is someone to talk nonesense to by the yard—let me know your new address soon, so I can write you a Christmas card.

Look after yourself and be good. God bless you!

Ludwig."

Trinity College, Cambridge.
1946.

"Dear Roy,

I'm feeling by far better now than I did at the beginning of term. I then felt very lousy and had queer attacks of exhaustion. Finally in despair I went to see a physician here in Cambridge who was known to

me as quite a good and conscientious man, but I felt sure that he couldn't help me. Well, he advised me this and that and in the end he mentioned that I might try a Vitamin B preparation, as a deficiency in Vit B sometimes had effects as the ones I had described to him. So I took Vit B tablets, without the slightest hope that they'd help, and to my great surprise they did help. I'm taking them regularly now, and I haven't had any more attacks of exhaustion. In fact I'm all tanked up with Vit B, I get so witty that the jokes get jammed and can't come out. Isn't that terrible?

The weather is chilly and damp, on the whole, and when you come home you might bring a little heat from Sumatra with you. The mosquitos you can leave behind, except for a few for my enemies.

I hope you'll come soon. Look after yourself. God bless you! So long!

Ludwig."

There began the last four years of Wittgenstein's life, a period of the greatest poignancy. He went first to stay in a little guest house in County Wicklow, Eire, being totally absorbed by work for his second book, the *Philosophical Investigations.* But the guest house was not private enough, and he moved in April 1948 to an isolated cottage by the Atlantic in Renvyle, County Galway. He managed to do some work, and made a local reputation as a tamer of sea birds; but he was profoundly unhappy, as his letters to his ex-pupil Malcolm show. All his life he longed for human warmth and sympathy, but I suspect that the standards he set for other peoples' thoughts and behaviour were so high that they precluded him from ever loving anybody, and the problems would be compounded if Wittgenstein were haunted by homosexual guilt feelings. The intensely private nature of his work must have served only to widen the gap between him and more ordinary mortals. These matters can be glimpsed in a letter that he wrote to Malcolm at about this time. The letter concerns Moore, with whom Wittgenstein had been professionally associated for many years; it beautifully conveys the Wittgenstein flavour:

"Now as to Moore—I don't really understand Moore, and therefore what I'll say may be quite wrong. But this is what I'm inclined to say: that Moore is in some sense extraordinarily childlike, is obvious and the remark you quoted (about vanity) is certainly an example of the childlikeness. There is also a *certain* innocence about Moore; he is for example, completely unvain. As to its being to his "credit" to be childlike—I can't understand that; unless it's also to a child's credit. For you aren't talking of the innocence a man has fought for, but of an innocence which comes from a natural absence of temptation—I believe that all you wanted to say was that you *liked* or even *loved* Moore's childlikeness. And that I can *understand*—I think that our discrepancy here is not so much one of thoughts as of feelings. I *like* and greatly respect Moore; but that's all. He doesn't warm my heart (or very little) because what warms my heart most is human kindness, and Moore, *just like a child,* is not kind. He is kindly and he can be charming and nice to those he likes and he has great *depth*—that's how it seems to me. If I'm wrong, I'm wrong."

By now Wittgenstein's health was deteriorating. He struggled on with the *Philosophical Investigations,* first in his cottage and then in a Dublin hotel. He sent pieces of the manuscript to friends (notably Miss

G. E. M. Anscombe at Oxford) and corresponded with Malcolm in America. Although Malcolm was sending him food parcels, Wittgenstein became more and more lethargic and a blood test in Dublin in May 1949 showed him to be anaemic; carcinoma was suspected and he had a barium meal, which was negative. He was treated with iron and liver extract, and he felt temporarily better.

Malcolm then persuaded him to visit America, and Wittgenstein sailed there on the *Queen Mary* in July 1949, spending a happy three months walking and talking philosophy with Malcolm and his colleagues. But he became ill again and was convinced that he had cancer: "I don't want to die in America. I am European—I want to die in Europe", he said to Malcolm. "What a fool I was to come." He was admitted to hospital, but no evidence of the disease was found, and he returned to England in October. But in December he wrote to Malcolm saying that he had been examined at Cambridge and found to have carcinoma of the prostate. Wittgenstein wrote that he was in no way shocked when he heard that he had cancer, but he *was* when he heard something could be done about it, for he was terrified of a lingering death. He was given oestrogens and radiotherapy at Addenbrooke's Hospital.

The next year of his life was spent variously in Norway and in Oxford, where he stayed with Miss Anscombe, who subsequently played a significant part in organizing the publication of the *Philosophical Investigations.* But he spoke of Oxford as a "philosophical desert"; an interesting remark, for Oxford philosophy was at that time very concerned with the kind of linguistic analysis that Wittgenstein had brought into being. He felt himself to be dying, and had a great fear of doing so in hospital. His General Practitioner in Cambridge, Dr. Bevan, told him that he could come to his house to die, and Wittgenstein was deeply grateful for this. Wittgenstein moved in and was cared for by Mrs. Bevan for the last few months of his life. By his standards they were serene months, and he even managed to work on his book (though the *Philosophical Investigations* were not published until some years after his death). Malcolm writes of his end: "Before losing consciousness he said to Mrs. Bevan, who was with him throughout the night, 'Tell them I've had a wonderful life'. By "them" he undoubtedly meant his close friends. When I think of his profound pessimism, the intensity of his mental and moral suffering, the relentless way in which he drove his intellect, his need for love, together with the harshness that repelled love, I am inclined to believe that his life was fiercely unhappy. Yet at the end he himself exclaimed that his life had been "wonderful". To me this seems a mysterious and strangely moving utterance."

It would be presumptuous of a non-philosopher to try and assess Wittgenstein's place in philosophy; that is obviously the concern of professionals. But it does seem that after the *Tractatus,* philosophy was never quite the same. Wittgenstein's influence on two or three generations of philosophers (particularly English and American) has been enormous, and twenty years after his death, publication of his early notebooks represents an important event in the philosophical world. But such men as Chomsky and Popper have come along and asked different (perhaps slightly less difficult) questions than Wittgenstein; they have moved the goalposts. This has nothing to do with the main subject of this article, which is Wittgenstein's life, and it is not my concern whether in a

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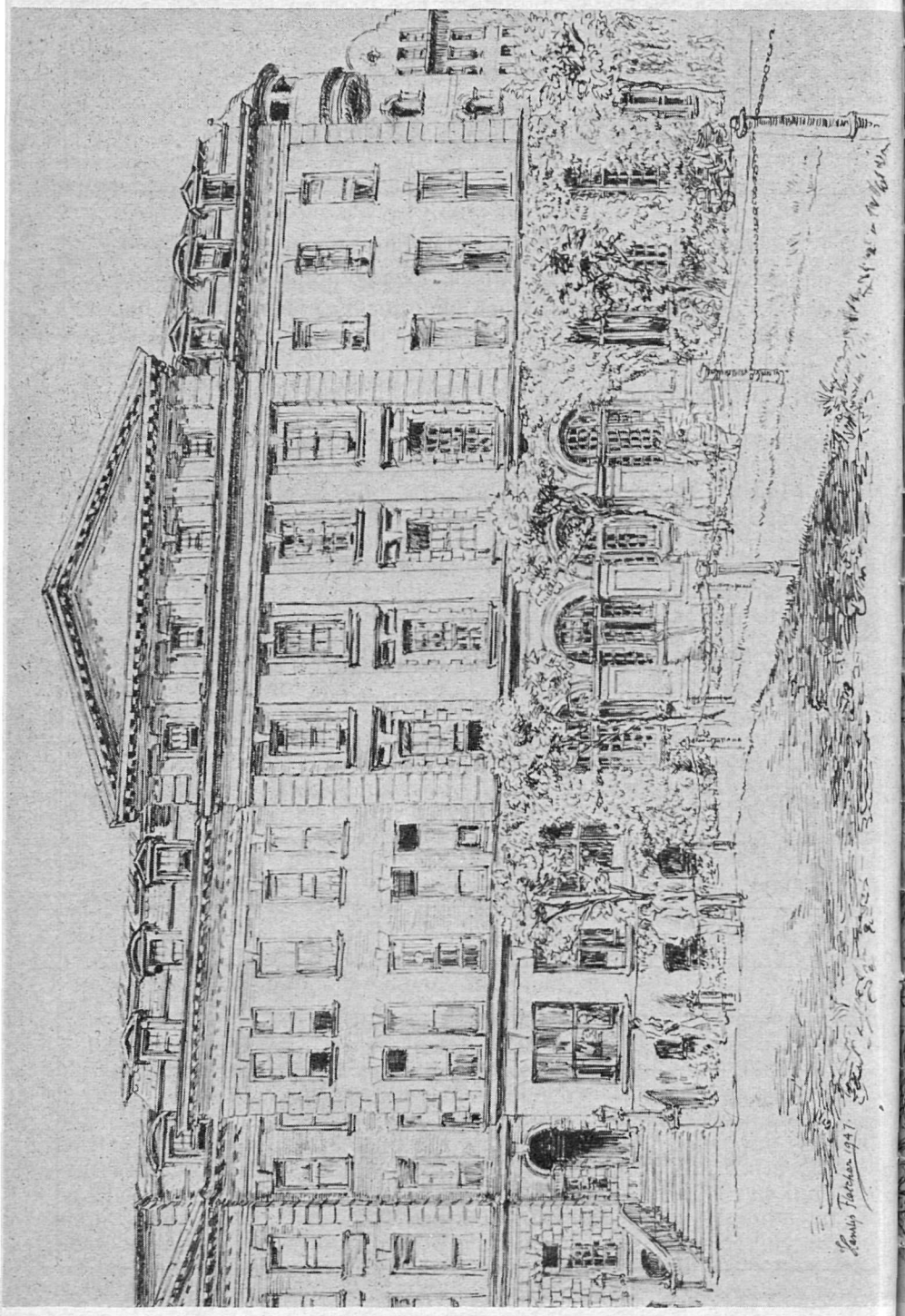

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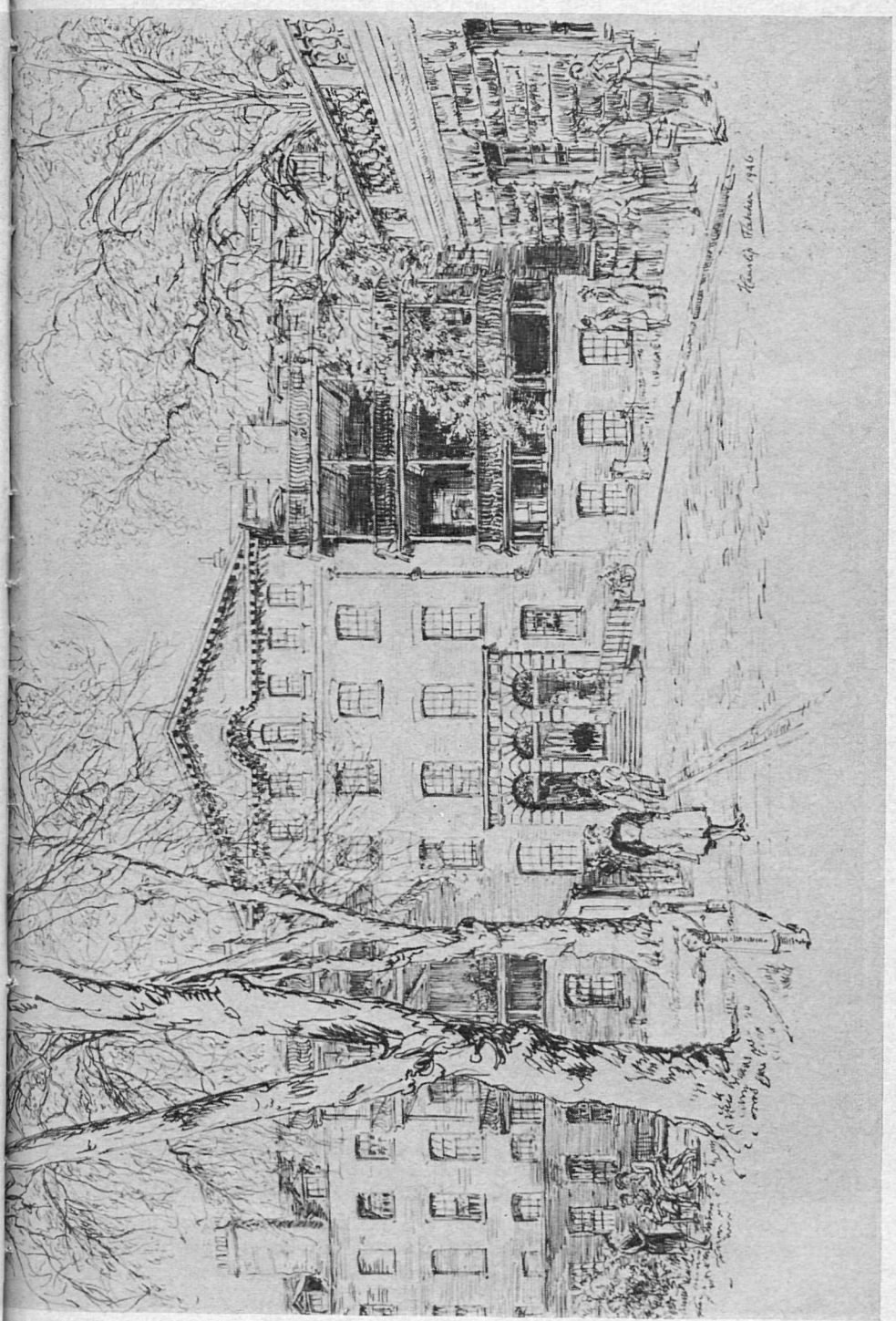

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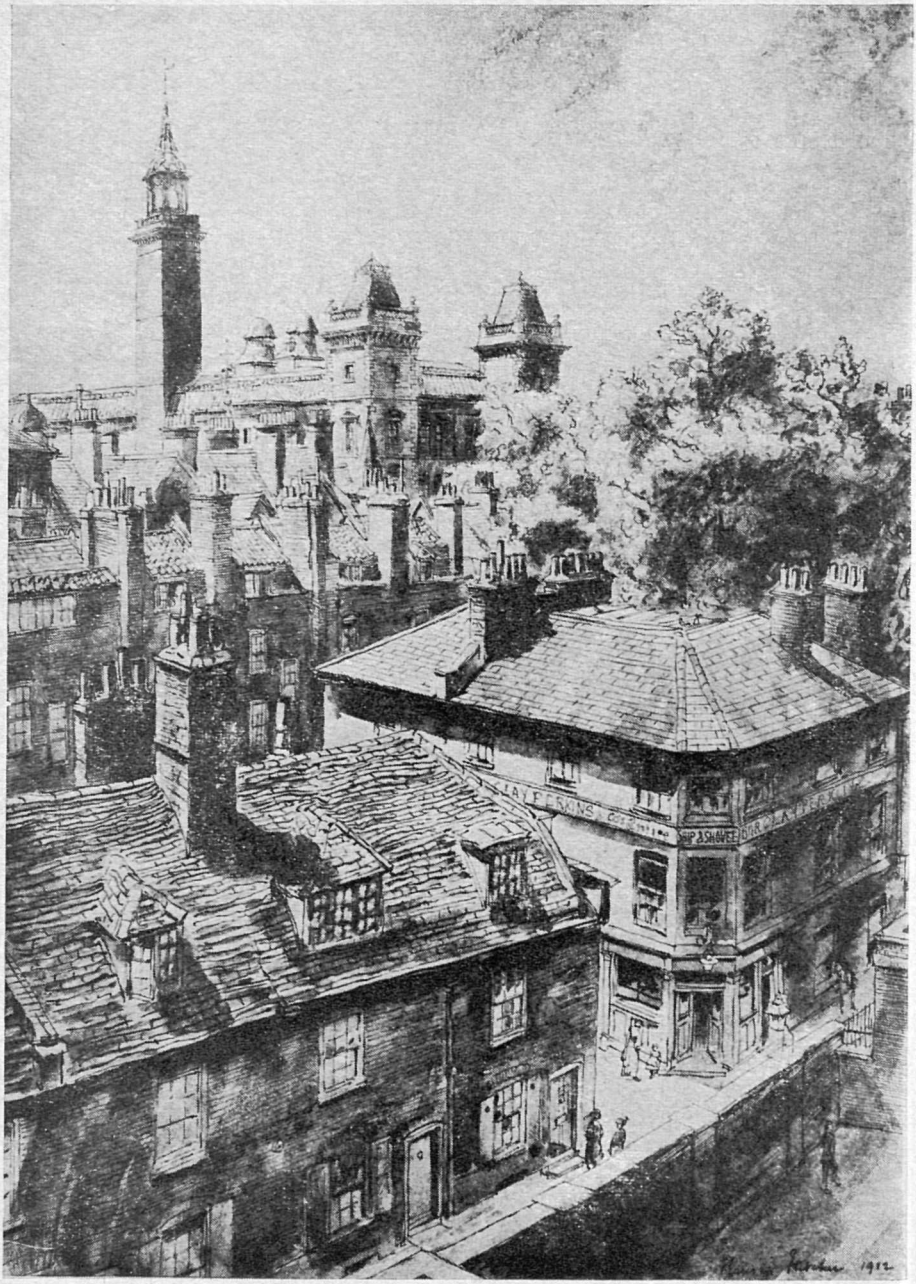

"The Ship and Shovel" 1912

hundred years he will loom large in the history of the subject. My concern is that (to borrow Malcolm's phrase) his life was mysterious and strangely moving, and I hope that I have conveyed a small part of that.

Acknowledgements

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The Work of the Hedley Atkins Unit

Ian S. Fentiman, M.D., F.R.C.S.

Sir Hedley Atkins, who was Professor of Surgery at Guy's Hospital from 1961 to 1970, founded the Mastitis Clinic in 1936. As its name suggests, the clinic originally treated patients with benign breast disease, but it has now become the largest breast cancer centre in Britain, treating over 200 new cases every year. When Sir Hedley retired in 1970, Mr. John Hayward became Director of the Unit. As a tribute to the work of Sir Hedley, the new 36-bedded Breast Unit, built at New Cross in 1969, was subsequently named after him. All in-patient treatment is carried out at the Unit at New Cross, but most of the out-patient clinics take place at Guy's which is also the location of the Breast Unit offices in Snowfie'ds Clinics.

Despite a heavy clinical work-load, the unit has a large research commitment, and it is this combination of service work and scientific research which makes the unit unique. The Imperial Cancer Research Fund provides the majority of the finance required for staffing the unit, and for the purchase of necessary equipment for innovative work.

Out-patients

The Unit deals with approximately 2,000 new patients annually, suffering from a variety of breast conditions. Most are seen at the New Patient clinic which takes place on Friday afternoons. To reduce anxiety, all patients are seen within two weeks of receiving a letter from the general practitioner. Apart from their Guy's notes each patient is allocated a second set of Breast Clinic notes and a B.C. number. These are essentially for research and are either retained in the Unit for Guy's, or taken to New Cross during the time of in-patient care. All relevant information from the B.C. notes is recorded on cards, and these data are stored on the University College computer. There is an on-line terminal in the Unit which is operated by a Data Manager. Each time a new symptom or sign is detected and recorded on the notes, this is transcribed onto cards and computerized within one week.

When first seen at the clinic the patient's history is obtained by the surgeon, but all details are recorded by a secretary who subsequently types the information into the research notes. Ninety per cent of women seen in the New Patient clinic do not have breast cancer and therefore the main function of this clinic is to detect those patients in need of surgical intervention, which is usually indicated when a discrete palpable mass is present in the breast. On clinical grounds a decision is made by the examining surgeon as to whether the lump is likely to be benign or malignant. Benign lumps frequently have an attempted needle aspiration to exclude the presence of a cyst. Patients with cysts which disappear after aspiration of non-bloodstained fluid are reviewed six weeks later. Those patients with solid lumps thought to be benign are admitted within a few days for excision biopsy, since the Hedley Atkins Unit does not have a waiting list for surgical patients.

Sir Hedley Atkins at the re-naming ceremony of the Breast Unit in 1975.

If the surgeon suspects the lump to be malignant, a Tru-Cut biopsy is immediately performed, using local anaesthetic. The patient then returns home, returning to Guy's a few days later to be told the result of the biopsy. If no malignancy is present in the Tru-Cut specimen, the patient is then admitted for biopsy under general anaesthetic. When the Tru-Cut biopsy confirms that a carcinoma is present, the patient is told the diagnosis, and admitted the following day for further investigation.

The majority of women seen in the New Patient clinic complain of painful nodular breasts and no discrete lump can be palpated. They are usually not re-examined but, as a safeguard, mammograms are performed on those over the age of 35, in order to exclude sub-clinical malignancy.

In-patients

Initially it was thought that the juxtaposition of women with suspected and confirmed breast cancer might increase the already high level of anxiety. However, this has not been the case. The patients derive a great deal of support from one another, and do not suffer the sense of isolation often experienced by an individual patient in a surgical ward surrounded by others with a variety of surgical conditions. Additional support derives from Nursing staff who are accustomed to dealing with women with breast cancer and are therefore able to anticipate many of the problems which arise in the pre- and post-operative periods. Finally, in order to maintain morale, patients with early breast cancer are nursed in a separate ward from those with advanced disease.

Once a histological diagnosis of cancer has been made, the patient is screened to determine whether the disease is localised. The ICRF has provided a radio-isotope scanner at New Cross which is for the exclusive use of the Breast Unit. The scanner is used to screen patients pre-operatively by bone scan, and it plays a role in the assessment of patients with advanced disease by bone, brain, liver or lung scans. As a further means of detecting metastatic disease, pre-operative patients have a biochemical screen on a sample of their blood, and in addition, mammograms are taken of the contralateral breast to exclude a second primary tumour or metastasis.

Most patients with operable lesions are treated by a modification of the radical mastectomy operation. In this respect, the mastectomy is the final staging procedure, separating those patients with involved axillary nodes, who may require adjuvant therapy, from those with uninvolved nodes who may not. Presence of metastases in the lymph nodes is an indication of the likelihood of micrometastases elsewhere, which if unchecked will eventually become clinically apparent. At present, the role of adjuvant endocrine therapy and chemotherapy is being investigated in the Unit.

The pathology laboratory is an integral part of the Hedley Atkins Unit. All biopsy material from both out-patients and in-patients is processed by the laboratory and reported on by Dr. Rosemary Millis, Consultant Pathologist. The laboratory provides a rapid service for the characterization of all tumours treated by the unit, in terms of histopathological type, grade, and stage. In addition, Dr. Millis provides the link between the Unit and the research laboratories of the Imperial Cancer Research Fund, so that representative samples of tissue from patients with both benign and malignant disease are selected for research purposes.

Follow-up

Patients who have benign breast disease confirmed by biopsy are seen once post-operatively and then discharged. However there are a few who are suspected on histological grounds to have a high probability of

recurrence, or possible malignant change, and these patients are carefully followed in out-patients. The Breast Unit has an open-door policy whereby all patients are told that they can be seen again at any time if they have any worries concerning their breast.

No patients with breast cancer are ever discharged from the follow-up clinic. They are seen at gradually increasing intervals so that by the time they reach the fifth anniversary of their operation they are on annual review. If recurrent or metastatic disease develops, they revert to more frequent review.

Management of advanced disease

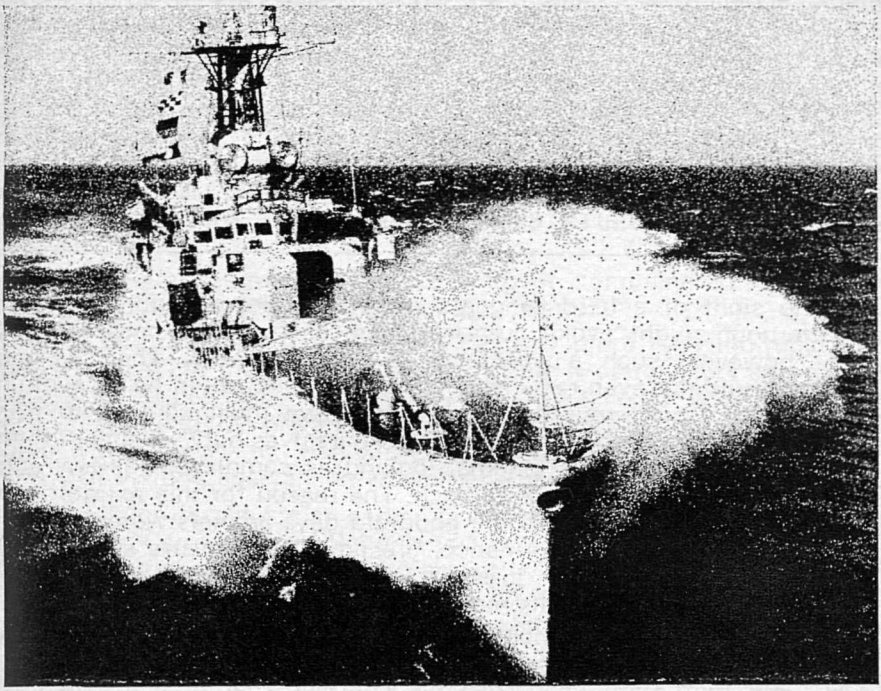
Those women with advanced disease which is beyond the scope of curative surgery can pose very difficult management problems. It is in this field that close teamwork is necessary involving radiotherapist, medical oncologist and surgeon. The Breast Unit runs a total of nine different out-patient clinics every week. This number is necessary because of the diversity of treatment regimes which are available, so that specific clinics are responsible for specific methods of management; radiotherapy, chemotherapy, endocrine therapy or adjuvant therapy of micrometastatic disease. Those patients who develop recurrence of their breast cancer are managed for as long as possible by local measures such as a combination of surgery or radiotherapy. Disease which has passed beyond the stage of local control is managed in the first place by hormone manipulation, either additive or ablative. When no further remissions can be obtained by endocrine therapy, treatment is then started with a sequence of cytotoxic chemotherapy regimes.

Research

In addition to clinical research projects, the unit collaborates with several laboratories at the headquarters of the Imperial Cancer Research Fund at Lincoln's Inn Fields. A long-term collaboration with Dr. R. D. Bulbrook, Department of Clinical Endocrinology, ICRF, has provided a wealth of information concerning the steroid hormone profile of patients with early and advanced breast cancer. Such epidemiological studies are necessary to unravel the enigma of endocrine involvement in the promotion of breast cancer. A much larger population study has been carried out on the island of Guernsey, to examine the hormone status of women from a normal population, some of whom may subsequently develop breast cancer. The third experiment is now in progress, and the object is to compare xeromammographic findings, risk factors and steroid profile in 5,000 Guernsey women.

Dr. Roger King, Department of Steroid Biochemistry, ICRF collaborates with the Unit and provides a service for the measurement of oestrogen and progesterone receptor status of specimens from primary or secondary tumours. This approach may allow a rationalisation of the endocrine management of breast cancer patients with advanced disease, so that the most appropriate therapy may be given.

Also at the ICRF, Dr. Joyce Taylor-Papadimitriou and the Department of Epithelial Cell Growth Regulation have been studying the cell biology of tissue derived from both benign and malignant specimens sent from the Unit. This work is concerned with the development of methods for the culture of epithelial cells in vitro, and the characterization of both normal and malignant cells in culture.



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ROYAL NAVY MEDICAL CADETSHIP

Thus it may be appreciated that the Hedley Atkins Unit is conducting a two-pronged attack on breast cancer, both treating women suffering from this disease, and also participating in projects which attempt to answer some of the fundamental questions raised by the biological problem of breast cancer.

Some Impressions of Egypt

by Dr. John Quarrie and Dr. Elspeth Earle

The sight of a herd of goats wandering down Oxford Street in mid-afternoon might evoke surprised glances from the passers by. In Cairo, however, such a spectacle is commonplace. The seasoned traveller would not even raise an eyebrow, so busy would he be avoiding the seemingly murderous traffic. However, we must confess to frank incredulity at a time when we considered ourselves duly seasoned; there, standing in the foyer of a cinema, looking as complacent as any actor at a film premier, was a large bullock. The reason for this extraordinary presence is apparently that in the good old days animals were sacrificed on the first night of a performance, presumably to ensure a successful run. Nowadays, with beasts in short supply, the sacrificial element has been dropped, but the animals remain.

The bullock in the cinema illustrates the astonishing diversity of Egyptian life. The dusty back streets of Cairo with their overcrowded hovels and tiny primitive workshops contrast sharply with the busy, traffic-choked main streets. But the contrast lies not just in the poverty of these streets but in the complete difference of life styles. The Egyptians are a very tolerant race and are able to allow different cultures to flourish side by side without any evident hostility.

The bullock also exemplifies the apparent domination of society by males. It is paradoxical, that while women appear to be discriminated against in society, the position of the mother as head of the family makes her extremely powerful. This need to maintain a role at the centre of the family may partly explain the reluctance of women to limit the size of their families when contraceptives are freely available.

Population control is certainly one of Egypt's major problems. 45 per cent of the population is under the age of 15, a total of 18 million children. The overcrowding is aggravated by the fact that 99 per cent of the people live in 3 per cent of the surface area of the country, huddled round the waters of the Nile. Yet no-one has any idea how to make family planning work in this country. The American contribution is to set up a lavishly financed unit to study the causes of infertility.

Hardly less incongruous was our attempt to teach the principles of child psychotherapy to eager young doctors. When half the children attending a Child Guidance Clinic are either educationally subnormal or suffer from epilepsy, it seems almost indecent to question their ego development. The paediatric service is certainly stretched to deal with this enormous child population.

The paediatric out-patient department at Al Azlar Hospital is awesome: four bemused doctors seated behind a table, trying, like

Canute, to repel the seemingly endless tide of young humanity. Bare chests hastily presented to the waiting stethoscope, a dash at the prescription pad, and away to join the throng at the pharmacy. The two minute consultation is a reality here.

Hospital admission presents different problems. Mothers are admitted with their children as a matter of course and share a bed with the child. Beds become a little crowded when younger siblings accompany mother, as they often do. Sometimes the cat comes too, but, mercifully, no goats. It is hardly surprising to learn that cross-infection rates are high.

There is a free medical service in Egypt, administered rather reluctantly by doctors within four years of qualification.

No one pretends that this provides any more than the most rudimentary care, but the vaccination programme is compulsory and reaches more than 90 per cent of the population. More comprehensive medical care is provided by private clinics, but at a considerable price. The clinic which we visited had x-ray and laboratory facilities and a wide variety of visiting specialists, as well as a number of experienced GPs.

Medicine is a popular career in Egypt. The annual intake at each of the three Cairo Medical Schools is 1,000 students. Selection is based on examination results, irrespective of whether the aspiring student wishes to do medicine or not. Even with a drop-out rate of nearly 50 per cent there are still 65 students for each cadaver. Lectures are conducted in English, the curriculum being similar to that in use here fifty years ago, and still surviving in some centres. After qualification every male doctor has to spend two years in the Army and two years in rural practice, following which many go abroad.

Public Health problems are immense with Rillaryia and other infestations looming large. Tuberculosis is common and the threat of a major epidemic is always present, due chiefly to the overcrowding. Rather surprisingly the Chairman of the Department of Public Health in Cairo considered environmental pollution to be the main problem in cities. There is also a steeply rising incidence of ischaemic heart disease and cancer in the cities, a trend which is not yet apparent in rural areas. Psychiatric illness is well represented, psychoses often being treated by long-term admission to mental hospitals. Neurotic illness is common, but doesn't merit the attention which it receives in this country.

A striking feature of life in Egypt is the central role of bargaining. This extends far beyond mere commerce; it forms the basis of many marital relationships for example, and is the principle which governs most traffic movements in Cairo. In its latter form it represents the ultimate expression of the art of "brinkmanship", with the motor horn providing an unnerving orchestration. The other feature of Cairo's main streets which captured our attention was the incredible number of shoe shops. Large crowds gather to peer avidly at lavish window displays. I was mystified by this preoccupation with footwear until we learned that in Freudian terms shoes are penis substitutes; but I'm still mystified, since judging by the birth rate, that particular commodity in not in short supply.

Any account of Egypt would be incomplete without reference to the incredible antiquities which abound. The breathtaking beauty of the temples and tombs defies adequate description. Somehow the presence

of these monuments helps to keep present day Egypt in perspective. It is an astonishing realisation that the way of life seen from the train as it follows the fertile Nile Valley differs little from that depicted in the wall paintings at Saqqarah approximately five thousand years old. As President Sadat has pointed out, a culture that has survived for 7,000 years is not going to crumble in the face of a few local difficulties.

Rented Accommodation Outside the Hospital

by Jo Hind, Accommodation Officer

Where to live—this is probably one of the biggest and most worrying problems facing any young person wishing to receive training or work in the Guy's Health District. In the heavily populated South East and with the many complicated facets of the Rent Act, good and realistically priced accommodation has become almost impossible to obtain. Because of the difficulties involved, the Hospital decided to set up a service to help and advise on the problems, some six years ago. The Accommodation Office staff help all students and employees in the Guy's Health District, who are welcome to come and discuss their housing requirements. Applicants should keep in touch daily to hear of new vacancies, as the turnover is so rapid. It is necessary to be in London to make arrangements with landlords in person.

Probaly the greatest difficulty of all is to maintain a good relationship between the landlord or his agent and the tenants. For one reason or another misunderstandings often occur, which could be sorted out by meeting together and discussing the problem. Failures to do so may end in unnecessary legal action. It is most important to maintain a good rapport with owners because they may have several properties let to people from Guy's, and unpleasantness with one set of tenants may mean that the owner will decide not to have any more people from the Hospital. It is very easy for the thoughtless few to spoil the market for the many good tenants.

We are fortunate at Guy's to have an accommodation service and the Accommodation Officer spends a great deal of time meeting landlords and agents, and inspecting properties to ensure that they are of a good standard, and within reasonable access of the Hospital. This often saves prospective tenants having to make a wasted journey to view a property. For example, there is little point in sending nurses to view a property in an area where it would be impossible to get to their ward in time for an A shift on Sundays.

Rents are discussed with landlords and agreed before the accommodation is placed on our register. Rents may sometimes seem high, but we have to remember that we are competing all the time with the private sector, and usually owners are very sympathetic and the rents we agree are lower than they would be able to charge on the "open market". There is no merit in moving into a flat and then trying to force the owner to reduce the rent—in the end the tenants will have to move out and none of that landlord's properties are offered to us again. In the isolated instances which I have come across where differences between landlords and tenants have ended in legal proceedings, it has been the tenants who have lost and been rendered homeless. We try not to accept

properties for our register which we know to be substandard, but negotiation with the landlord will often result in his providing new furniture etc. or paint for the tenants themselves to decorate. Sometimes a flat or house will be in good condition, but perhaps not to the taste of the individuals. Before any changes are made in the decor, the landlord's agreement should be sought, and permission is nearly always given—provided that the ideas are moderate and acceptable to the owner.

To sum up, the housing situation in London is extremely difficult, and the Rent Act does nothing to help either landlord or tenants. We have to accept the difficulties, and try to maintain the best possible relationships all round. We must live within the limitations imposed by present day problems, accept the inevitable, and above all preserve the good name of Guy's.

Finally, we in the Accommodation Office would like to reiterate that we will always do our best to help all comers—not only in the search for a home, but also with any queries or difficulties appertaining to housing generally.

Simon Stylites

ODE TO THE POPULAR PRESS

(After Flann the Man)

Clears throat and strikes heroic pose . . .

1. When "*The Times*" is on strike and out of sight
   You do the best you can.
   When grieved it's to the *Sun* you write.
   For the popular press is your man!

2. When the lack of the crossword makes you feel strange
   And your face is pale and wan
   Why it's off to the *Mirror* you go for a change
   For the popular press is your man!

3. When the surfeit of Levin's eloquent arts
   Have muddled you ere you began.
   You turn with relief to Proop's broken hearts
   For the popular press is your man!

4. When the *Guardian*'s marred by compositor's slips
   When the *Mail* backs your also-ran.
   You turn to page 3 with a leer on your lips
   For the popular press is your man!

5. When the *Telegraph*'s filled with choleric ire
'Gainst the whalers of Japan
You turn to "Fireman saves kitten from fire".
For the popular press is your man!

6. *The popular press! The popular press!*
When the outlook is dark and tends to depress
When you see only grief you turn with relief
To the popular press for your man!

S. S.

Nursing

At the moment she first steps into her uniform, Mary Smith becomes Nurse Smith. She was a person with individual characteristics and feelings and she becomes A Nurse who looks like all other nurses and does not express feelings (except occasionally in the sluice).

This outrageous statement is unfortunately true to some extent, and it is interesting to consider how much these two things—the uniform and the loss of a Christian name—make a nurse lose her individual identity to patients and colleagues, and whether this matters.

Of course, nurses need to wear some sort of special clothing for reasons of cleanliness and infection control. Our traditional uniforms are gradually being whittled away by economies in the sewing and laundry departments, but we always choose something as similar to the old style as possible. We have not learned from the children's nurses, many of whom have realised that bright colours and other varieties of dress help to stimulate their patients and make them feel more at home, or from those of our psychiatric colleagues who have abandoned uniform altogether.

Uniform not only gives all nurses an air of detachment, but also identifies the different grades, so that everyone knows who has the most authority. Many patients give all their confidences to the most junior nurses because they seem less frightening, and some may address every question to the sister because they think she knows all the answers. At St. Christopher's Hospice the sisters, staff nurses, auxiliaries, domestics and visiting students all wear the same colour and the differences which denote rank are not obvious. This has the interesting effect that a patient can talk to any individual with whom he feels comfortable.

Traditional uniforms do make nurses pleasing to the eye (important when you are ill), and carry the aura of the tradition of nursing service (identity of a different sort). I have to admit that I am one of those who lovingly sews my old uniform together again and again, and that I was horrified by the nurses I saw in America who wore an assort-

ment of crimplene trouser suits. After what I have just said this seems rather puzzling; perhaps I, and all the traditionalists should question our motives a bit more closely!

And what of the names? In most groups now, Christian names are the ruie (even the doctors are ahead of us there). This is not necessarily better or worse than previous more formal ways of address—it is just the way things are. Many patients will feel happier and better able to relate to Nurse Smith if they call her Mary. Nurse Smith will feel happier for—after all her Christian name is a personal part of her and you can't help other people without showing something of yourself. Patients are quick to sense how the sister feels about this and will tactfully not refer to Nurse Smith as Mary in front of her if she is likely to disapprove. However if she not only does not mind, but even calls Nurse Smith "Mary" herself now and then (all the other nurses in the ward do anyway) she may be rewarded by getting to know the nurse better and being in a better position to support and teach her.

Some patients would hate to call the nurses by their Christian names let alone be addressed that way themselves, and nurses should be sensitive to what is best for each patient. Some "old school" nurses would also find it difficult to be so familiar—they just weren't brought up that way—but, if they wish, they can still show an attitude of concern for individual patients and nurses. In the end what matters is not what people are called or what they wear, but the way in which they behave and are treated. Uniform and etiquette certainly have their place. In the past they were not a barrier because formal behaviour was the norm, but if we stay behind the times for no good reason are we in danger of stopping effective communication between human beings?

Julia Fabricius.

Physiotherapy

At a meeting of superintendents and teachers of physiotherapy in Lancaster at the beginning of this month, a speaker was adjuring us to think in terms of what use we are to mankind, and in what areas we can and in what we cannot contribute anything of value. He postulated a situation in which, at the present growth-rate unless we all did this, half of us would be, professionally, caring for the other half by the beginning of the next century, a situation which he felt was as exact in definition of hell as we are likely to be able to make.

How, he further asked, are we to distinguish between need, want and expectation? How are we to be persuaded to make evaluations not only of our own usefulness but also of our patients' actual requirement of our skills? (Instead of relying on the assessment of others? How indeed?).

While not for one moment conceding anything in the running battle to hold what we have and to regain what we have lost, one has to recognise the basic truths which lie beneath what was put to us. But how

to set about these tasks? We have Guys' physiotherapists who have done, are doing or are about to do M.Sc. courses at the University of Surrey, physiotherapists who have been able to develop their intellectual abilities and their critical faculties. Elsewhere, there are therapists following similar courses at Southampton and at Loughborough, and we are, as a group, slowly deriving benefit from their studies. A surprisingly large number of our teachers have squeezed the time and made the effort to follow Open University Courses and gain graduate status. But observation of other highly academic and erudite professions in spheres allied to our own does not suggest that the possession of first or subsequent degrees is per se an indicator of effective self-appraisal.

Perhaps Prof. Clegg's comparability study will do it all for us, but that's not really the point. We have no deficiency of critics from outside but we do have a genuine dearth of realistic self-evaluation.

Yet for all that, there has been an enormous rationalisation of physiotherapy in the last quarter-century. Rationalisation is probably not the appropriate word in that pure reason can hardly be said to reign in such a subjective, personal realm as ours. Let us say, rather, that a lot of irrationality has been disposed of, and that—to our credit—we are bringing up young women who are encouraged to question and to explore the bases of the therapeutic activities they engage in.

Who can tell, though, whether what we give to patients or what we make them give, is what they really need rather than what they (and we) think they need? This surely must be an unanswerable angels-on-the-head-of-a-pin question?

But the message is there—we cannot hope to expand, we or anyone else in the N.H.S.—to fill all the demands made on us or created by us. Neither can we be expected to be any more objective than anyone else in the N.H.S. in deciding where and when and how much. We think we have a lot to offer—why else would we do the job? Others speak of us as a scarce and valuable resource that needs optimal deployment. By whom and where? Are we too close to our own problems to be able to make sound judgements, or are we the only people who know enough about our own potentialities to be able to do so?

R. J. Cooper

Book Reviews

"Cash's Textbook of Medical Conditions for Physiotherapists", 6th edition, edited by Patricia A. Downie. Pp. 344. Price £5.25. Published by Faber & Faber, 1979.

Miss Cash's first edition of this book was published in 1951 and has undergone a series of reprintings and revisions in the intervening years. Now, Miss Downie has taken over the editorship claiming to put the writings of the twelve contributors together "in a rational manner" but disclaiming much else. However, there is a new dynamic evident in this series of books designed for students and practitioners of physiotherapy, and Miss Downie must take much of the credit for it.

The book opens weakly with some chapters on basic pathology which could probably be omitted. The coverage is superficial and students would probably do better to consult a standard textbook. The meat of the book is in the chapters on joint disease, in which some excellent

commonsense, robust and simple advice is given to physiotherapists while painlessly interlarding it with some intelligible information about complex problems.

Other health-care professionals than physiotherapists could read these chapters with profit, for their realistic and sensible attitudes.

A second lengthy section is devoted to paediatric physiotherapy, and will give students a good foundation for what might essentially be considered a post-registration study, and shorter but useful chapters deal with skin conditions and burns.

Miss Downie contributes a chapter on terminal care and the physiotherapist, on the same lines as in her Cancer Rehabilitation book, with, again, a calm, reassuring, practical theme.

The book should, perhaps, evolve into separate volumes one on arthrology, for example, another on paediatrics—in the way in which others have sprung forth on neurology and chests. We are expecting more and more of our third year students and they well merit the help that the books in this series provides them. That they are available in paperback and that they are regularly updated is of great importance, and there can be no doubt that they are essential reading for all physiotherapists.

R. J. COOPER,
Dept. of Physiotherapy.

"Atlas of Nuclear Medicine. Vol. 4, Bone" by Dibos and Wagner. Pp. 197. Price £24.50. Published by Saunders, 1979.

This volume, like the previous three by DeLand and Wagner, is based on the large experience of the Department of Nuclear Medicine at the Johns Hopkins Hospital. The authors state that it is meant to serve as an "illustrative reference", and it must be judged by these standards.

Inevitably, one can always find gaps in a work published at such a reasonable price (for a nuclear medicine work!), and it is surprising that there is no example, or mention of pulmonary uptake in secondaries from osteogenic sarcoma, but such criticism is minor compared with the overall high standard of the volume. The format is easy to read, and the standard layout which allows the reader to attempt to evaluate the images with or without the clinical data, and then to compare his interpretation with the "approved version", makes the most of the teaching value.

Who should buy such a book? The authors suggest that it is for nuclear medicine physicians, radiologists, internists, oncologists and general surgeons, amongst others. More realistically it should be available in every nuclear medicine department, both for reference (is the bone scan of value in fibrous dysplasia?) and for teaching. In this latter context the correlation of the images with Dahlin's Mayo Clinic data on sites, age and incidence of bone tumours is particularly useful.

In summary, a good book which should definitely be in every nuclear medicine departmental library and probably in every hospital library. Not a book for the medical student to buy, but one which might well interest him to read.

A. J. W. HILSON,
Senior Registrar,
Nuclear Medicine Department.

"Saunders Tests for Self-Evaluation of Nursing Competence," 3rd edition, by Drs. Ann Gillespie & Irene Barrett Alyn, Price £7.75. Published by Sanders, 1978.

This weighty American tome is designed for basic student nurses so that they may check their knowledge. It has four main sections—Maternity and Gynaecological Nursing, Paediatric Nurse, Medical-Surgical Nursing, Psychiatric—Mental Health Nursing. Each section contains a series of brief case histories followed by a number of multi-choice questions. The number of questions varies—for example, there are 217 on normal pregnancy, 65 on pre-eclampsia. Answer blanks are available at the end of the book and the correct answers are provided. There is a bibliography with each section.

This book would obviously be of greater value to American students; the social arrangements for patients are different and the names of the drugs vary, but there is enough common ground for nurses in this country to find it useful. It is unlikely that a nurse would wish to buy this book for herself, but it might be a useful one for the nurses' library and would certainly be a help to tutors struggling to make up multiple choice questions!

B. B. WHYTE,
Director of Nurse Education.

"You and Leukemia", by Lynn Baker, M.D. Pp. 205. Price: £5.00. Published by Saunders.

It is nice to find a handbook on a paediatric subject written specifically for the affected paediatric patient. This

monograph of childhood leukaemia has been written especially so that it can be read by most children over eight or nine and understood by children of all ages. Naturally it provides the parents of affected children with many insights into the disease and its management.

The author was a medical student at Mayo Medical School when she had the idea of writing especially for patients, and she has demonstrated with great skill how a doctor in training can usefully add to the established practice of medicine.

The style is very American and therefore not to be read by scholars of the English language. However, this fact is not important when the value of the content is considered. The book is beautifully illustrated and there is a most useful index in which all key words are phonetically spelt.

Undoubtedly this handbook should be read by all families unfortunate enough to have a child affected with A.L.L. Unfortunately in these inflationary times it is sad that all such families cannot be given a copy free, gratis and for nothing.

RICHARD S. TROMPETER,
Lecturer in Paediatrics.

"Malignant Diseases of Infancy, Childhood and Adolescence", by Altman and Schwartz. Pp. 531. Price: £20.00. Published by Saunders.

This volume represents the eighteenth in the add-on series Major Problems in Clinical Paediatrics. The majority of paediatricians must be familiar with this series which represents a vast reservoir of clinical detail and reference. The practising paediatrician does not find himself confronted with a new malignancy many times a year, but the possibility that such is present must be included in the differential diagnosis much more frequently than actual cases found. Malignant disease is second only to trauma as a killer of children above the age of one year; however, advances in paediatric oncology over the past two to three decades have resulted in markedly improved survival for many forms of childhood cancer.

The first seven chapters are devoted to general aspects of childhood cancer, namely epidemiology, diagnosis and treatments. The chapter on cancer chemotherapy gives much useful information on the pharmacokinetics of individual agents which adds perspective to the therapeutic regimes referred to in later chapters. Only eight pages are allowed in which psychological and social support are discussed. This may be sufficient for such an individual text-book of oncology but let us not forget there is an art of paediatric practice in talking to children and their families. There is a most helpful section on "oncologic emergencies" frequently overlooked by the resident paediatrician when the oncologist or haematologist is not at hand.

The chapters on solid tumours and the leukaemias are most comprehensive and this book must therefore be a most useful source of information for the general paediatrician who acts as the primary physician. The value of this publication can be summarized by the quotation at the beginning of chapter two:

"In its beginning the malady is easier to cure but difficult to detect, but later it becomes easy to detect but difficult to cure."—Niccolo Machiavelli.

RICHARD S. TROMPETER,
Lecturer in Paediatrics.

"The Drug, The Nurse and The Patient," by Falconer, Sheridan, Patterson, Gustafson. Price £12.00. Published by Sanders, 1978.

This is the latest edition of a well known text book. It has an introductory section which includes general information about drugs followed by a section on the action and use of drugs used for special purposes, a section on the use of drugs for infants, and a comprehensive account of drugs used for common medical/surgical conditions. A "current drug handbook" is included.

Any English nurse using the book would of course have the usual difficulty with the names of the drugs, but this should not be an insuperable problem. Some sections of the book could with advantage have been pruned (for example, the section on the use of barbiturates), and the section on ganglion blocking agents could have been brought up to date, but these are minor points. The unique format of the book with its "linking" of drug, nurse and patient makes it one of the most valuable books in any nurse's library.

B. B. WHYTE,
Director of Nurse Education.

"Behavioural and Social Aspects of Contraceptive Sterilisation" by S. M. Newman & Z. E. Klein. Pp. 286. Price £12.00. Published by Lexington.

This book is more interesting than its rather formidable title might suggest, even if in some ways it is quite specialised and technical. The issues it addresses are of enormous importance. Contraceptive

sterilisation refers to vasectomy for males and tubal surgery, preferably laparoscopic for the female, operations performed with contraceptive intent. This book discusses these activities from a world wide perspective—a large number of people are involved, the estimated number of couples (x2 for people) controlling their fertility by sterilisation increasing from 20 million in 1970 to 75 million in 1976. Detailed and well annotated review are given of economic and sociological aspects and there are particularly useful reviews of studies of psychological consequences (including complications) of sterilisation in men and women. The importance of preoperative counselling (part educative) of both partners (whoever is to have surgery) is made clear. These chapters are likely to be most relevant to clinicians in this country. Others will also be pleased to have access to the range of demographic and other figures contained herein and referring to most parts of the world. Clinicians working in this field should have access to this book.

J. P. WATSON,
Professor of Psychiatry.

"Arthritis, Rational Therapy and Rehabilitation", by Robert L. Swezy. Pp. 242. Price £10.50. Published by Saunders, 1978.

The author of this book is an eminent American physiatrist (rehabilitationist to us) and in effect, deals with all aspects of non-pharmacological and non-surgical treatment of rheumatological disorders. This, of course, is an area that is of paramount importance if the patient is to achieve a reasonable end result of treatment. It is an area that is often glossed over in most textbooks of medicine and all but the largest textbooks in rheumatology. The benefits of rehabilitation are self evident—at least to the patient—yet many doctors are sceptical and regard rehabilitation as an art imbued with mystique that is best relegated to physiotherapists and occupational therapists.

This book should help to dispel some of that scepticism, but not all! It deals extensively with the rationales and methods of exercise therapy, joint conservation and protection, orthotics (surgical appliances to the uninitiated) and physical methods of pain relief. The book is clearly directed at a North American readership and differences in clinical and therapeutic practice, delivery of health care and administration of social services would clearly diminish its usefulness in the United Kingdom. Nevertheless, there is much in the book that is of universal interest, and it is recommended to those involved in the rehabilitation of arthritic patients, either in hospital or in the community.

R. GRAHAME, Consultant,
Arthritis Research Unit.

"Rheumatologic Interviewing and Physical Examination of the Joints", 2nd edition, by Howard F. Polly and Gene G. Hunder. Pp. 286. Price £13.25. Published by Saunders, 1978.

The title of this book is somewhat misleading. It is not a tome restricted to the history taking and examination of the locomotor system, though this is its main purpose. As each area of the body is covered in turn, there is a description both of the normal anatomy and of morbid anatomy. Thus the reader gains not only a system of history taking and examination, but also a detailed insight into the recognition of disease processes. Though there is little in this book that cannot be culled from textbooks of anatomy, clinical rheumatology and orthopaedic surgery, the presentation of all the relevant material in one volume has undoubted merit. It is more likely to be of value to the specialist than the generalist, though for all students of medicine it is recommended as a reference book rather than for comprehensive reading. The illustrations are numerous and of reasonably high quality. It is unfortunate, however, that the blue print used to denote synovial membrane in several illustrations comes through as a smudge on the backing page. One final point, one cannot easily forgive the authors for deliberately omitting a description of the neurological examination of the lower limbs in the chapter devoted to the spinal column.

R. GRAHAME,
Consultant,
Arthritis Research Unit.

"The Shoulder and Neck", by Bateman. Pp. 790. Price £32.75. Published by Saunders.

I am delighted to see the second edition of this remarkable book. Already a classic, it is accepted as the standard authority on shoulder surgery throughout the English-speaking world. Its scope and richness attest to years of careful observation founded on an encyclopaedic knowledge of shoulder surgery.

The first part of the book leads the reader gently from first principles of embryology and anatomy to analysis of the complex movements of the neck and

shoulders. The impatient may be tempted to skip this part, but only the most erudite will do this without penalty: much obscure but important detail is explained with exemplary lucidity. There are also many pages of photographs showing details of surface anatomy on a model.

The second part of the book deals with investigation. There is a good account of discography but due emphasis is placed on clinical examination too. I would have been interested to see a section on contrast radiography of the rotator cuff. This seems more useful than shoulder arthrography, which is described in great detail in the book. However, both techniques are evolving and time may change our attitudes.

The greater part of the book is devoted to the description of various disorders of the neck and shoulder and to their treatment. I was disappointed to see so much emphasis placed on postural deficiencies as a cause of chronic pain. The concensus of opinion now favours intervertebral degeneration as the chief culprit in neck pain. Fibrositis too still gets a good deal of space, although the lesions have never been demonstrated convincingly either at operation or at post mortem. However, it is in its descriptions of operations that this book is without peer. The felicitous text is beautifully illustrated with photographs and diagrams. Most of the operations have been done hundreds of times by the author. No spurious detail is included but important steps are meticulously detailed. It is truly a surgeon's book and no Orthopaedic Surgeon's shelves should be without a copy.

M. WATSON,
Consultant Orthopaedic Surgeon.

Correspondence

We regret that due to industrial inaction on the part of Post Office, much of your correspondence has failed to reach us.

Language and Sir Keith

Sirs,

There was real irony in the reviews of Professor Keith Simpson's talk published in last month's Gazette.

Professor Simpson stressed the importance of "the skilful use of appropriate words." His talk was reviewed in such a way that inappropriate words and phrases were used albeit with considerable skill. It is probably only my ignorance which prevented me from understanding some of the words used (solipsism, pariah, recondite (to which I shall return), seriatum, concatenated, orotund, interosculatory) and my linguistic ineptitude which left certain phrases rather obscure in my mind; 'that effective communication is parasitic upon succinct expression', or 'that linguistic precision is the condition of effective communication' or 'convoluted rhetorical Sputnik.' The worst sentence was this (it may have been a misprint): "Of course, the emphasis on linguistic accuracy does not imply that all language is declarative, is fact-stating."

The talk was, as the first (anonymous) reviewer notes, abounding with pieces of recondite information! And both reviewers reflected this beautifully (Recondite: Adj. 1. Incomprehensible to one of ordinary understanding and knowledge). In this respect the reviews were both masterpieces demonstrating 'the skilful use of appropriate words'. But for readers like myself who have been intensively trained from an early age in scientific and medical subjects to the detriment of English and the classics, the talk and particularly the reviews left me wondering whether anything had in fact been said at all, so obscure was it in the labyrinth of beautiful but archaic English.

Your faithfully,
David W. Denning.

Boland House,
Guy's Hospital.

One of our reviewers replies:

It is a great pity that David Denning should feel so trapped within his vocabulary as to find ventures outside of it both unstimulating and intimidating. Furthermore, he restricts his personal development by regarding his particular command

of words as *the* yardstick of effective communication. He seems to view medical training as an obstacle to literary development yet Professor Simpson did not find it so: it is a lame excuse. Comments like David Denning's are particularly distressing in that they combine a lack of curiosity about language with an almost Pavlovian antipathy to generating any curiosity, whilst displaying a self-imposed semi-literacy that does him no credit.

Our other reviewer contents himself by suggesting that whereas rats can be intensively trained from an early age, humans should be able to educate themselves—assuming they have the inclination and application to do so.

The beautiful Park

Sirs,

After some criticisms of the condition of the Park which have been voiced previously in your estimable columns, I feel that the present display deserves due credit for colour and design. The Park now looks a far more cheerful place—especially as the grass seems to be recovering from the devastation caused by the Tug-of-War competition in Charities' Week.

Yours sincerely,

M. W. RICHARDS.

London, W.1.

Sport

This month has seen the Guy's sportsman in his alter ego, that of the hard working, exam passing student. He has had to foresake many of the pleasures of the sportsfields and return to his study to learn of the long forgotten mysteries (to him) of the human body and to stare out at the warm summer sun and dream of what might have been. The Guy's sportsman has thus been working 25 hours of the day sneaking off only occasionally to partake of the pleasures of tennis court and cricket field, to hear ball on gut (cat variety) and leather on willow, squeezing such pursuits into the limited time available while learning the infinite workings of Man. All of which goes to explain why hardly anyone has written any sports reports this month, and why to maintain the size of the sports pages from the theiving hands of Ade and Phil you've got to read some more of this rubbish from me.

Of the sports reports available apologies to Stuart Matthews for the shortened version of his Golf report but because neither I nor the printers could read some of it and because of libel laws it had to be edited somewhat. Andy Morgan has also written a tennis review in his own inimitable style, and being a *laissez faire* type of sports editor (or just lazy—apologies for pun) he stands or falls by his report which is as he writes it. Believe it or not Andy is quite a fair fellow in real life. On the cricket scene the captain, Charlie Tunnadine informs me (by word of mouth and not of pen) that Guy's have floundered after their early season start, being knocked out of both Cup Competitions all be it in controversial circumstances. All will be revealed when Charlie writes his season's survey for the next *Gazette*. Incidentally both Charlie and Alisdair Jacks have recently been touring with the London University XI and although all four matches were lost, it looks well for Guy's cricket that we are represented fully in the university team. The water polo team recently went on a tour, winning all their matches, however they must have drowned in some liquid (water or ale?) because a report I have not. Another literary genius ruined by exams perhaps.

Apologies are also in order from myself I'm afraid. Last month I was sent by Guy's into the wilds of regional medicine for two weeks of Paediatrics and thus was not present at the proof reading. Ade and Phil, editors extraordinaire, brilliant though they are do not understand sport and thus a few minor mistakes were made. Firstly and foremost apologies to the ladies 5-a-side teams in the Summer Festival who rated hardly a mention in Revlac's report (Revlac has been severely reprimanded). The winners of the tournament were Thunder thighs consisting of Cathy Irwin, Debbie Owins, Caroline Fraser, Elaine Dare, Sally Everett and Clare Keyte. Two goals were scored in the final by Cathy Irwin and one by Elaine Dare with no reply by their opposition, Cellulose Strippers.

Other slight mistakes last month in-

volved a Cricket 2nd XI report being included in the 1st XI reports and the wrong sport being quoted in the correspondence columns. Apologies for these mistakes I'm sure you all spotted. We will move on to greater things.

An editor's life is not an 'appy one. It is now way past my bedtime and still I struggle with prose, trying to entertain you, trying to write in the style of Cardus, Woolridge and Earnshaw, and failing dismally. However even in these troubled times our spirits are occasionally uplifted by the arrival of unexpected copy at the eleventh hour. I refer to Alisdair Jacks who as 'Jaded' has recently arrived with cricket news, which you hopefully (Ade and Phil permitting) find gracing these fair pages.

Next month sees the time to start training once more for the coming Rugby, soccer and hockey seasons. Time to reduce the summer beer belly and activate long forgotten muscles (to stiffen to immobility by next morning). It's amazing how much keener you become on training when you're captain! I know that Guy's doesn't pay too much heed to sporting achievements in relation to academic standards these days but when the Admissions Committee sort through the UCCA clearing forms this summer would they care to bear in mind the Second XI soccer team need a centre forward for next season. Good luck to all sportsmen next month and START TRAINING.

G. D. Calver

CRICKET

The cricket club has not had a particularly good time as far as its affiliation to the University of London C.C. or to the two major cups, in recent weeks. Firstly, after our abortive first attempt at a quarter-final with Charing Cross in which we were going well at 70 for 2 when thunder intervened, we lost in the replay. Batting first at H.O.P. we slumped badly early on and only Charlie Tunnadine with an excellent 71 and Alex Williams looked at all at home as we totalled 115. When Charing Cross replied it might well have been enough if we had held our catches; however after having them struggling at 9 for 3, no less han six different nameless players dropped a variety of catches from the hard to the very, very easy indeed. So we lost, after having high hopes in this years U.H. Cup.

The U.L. Cup (in which we beat Charing Cross in the quarter final) was an entirely different and maddening story: the club was contacted by the secretary of U.L. to say that we should have played the semi-final the previous day, that King's Cottage Hospital had tried in vain to contact us to arrange it the week before and that the final was to be played the following day between King's and the L.S.E. King's did not contact us at all through any of the obvious or more subtle channels, so it's a bit late to say that we would, of course, have beaten either (or both) of those sides off the park! We shall however be attending the A.G.M. of U.L.C.C. in force to protest.

On a slightly more distant note, Charlie Tunnadine and Alasdair Jacks represented the University in the annual British University Sports Federation tournament held this year in Edinburgh. Last year, in London with Mike Glover as captain London won this tournament. This year however we did not. And how! After travelling by mini-bus over night to Edinburgh almost totally without sleep we were thoroughly beaten by Scottish Universities. The sensible thing to do—get an early night and be fit for Welsh Universities the next day; what did we do? go out and have a few beers, and then get bowled out for a convincing 86 by them (Tunnadine 26). We lost by eight wickets. At this point I must explain, for those readers who envisage cricket as stopping somewhere not far north of Newcastle: cricket in Scotland flourishes, on lovely tracks (the best I have played on this year!) and the cricketers are certainly fed excellently—I'm not certain but I think the regular gourmet lunches may have been our downfall finally (or was it the nightly team vindaloos or the genuine lack of talent in our batting department?).

Anyway by Wednesday, anything but refreshed, and in the company of a late arrival who last year was significant in our B.U.S.F. victory (making two of us who played both years) we lost to Irish Universities on the very beautiful ground at Fetters College. We let them off the hook and they raced to 210 for 6 (Jacks 3–23) but in reply we looked set for a win at 89 for 2 with 30 overs left before subsiding characteristically to 171 all out (Jacks 39). There weren't many incidents in this match—only one in fact; Charlie managed somehow to clear a rather distant line of tall chestnut trees with an enormous straight driven six that leaves most Glover blows in the shadows.

Thursday was a rest day, before being beaten even more thoroughly by Oxford University Authentics (Tournament champions). They rattled up 279 for 6 in 50 overs—a good batting side fed by some wayward bowling who took full advantage of some geriatric fielding.

In reply we managed 179 all out, our skipper Keith Harsham, from U.C.L. making a lovely 95. A few moments of light relief were provided by our "punk" No. 11 who, as the last wicket fell, raced in from the field watched by astonished (and strolling) Authentics team.

This side deserved to come last, we were without our five best batsmen, short of sleep, and basically not good enough; however we had a good week despite the mini-bus ride back which took 12 hours; and hope for better things next year in Oxford.

Jaded.

Guy's 2nd XI v. The London Hospital

The day started with two major shocks. Firstly, it wasn't raining and secondly, the London team arrived only 45 minutes late, which threw Guy's into a mild panic. As usual Genghis Gulamali lost the toss, and Guy's were put in to bat.

Captain Genghis had already decided upon a reverse batting order, so the innings opened with a fine stand of four runs between Tim Jennings and Jim Oliver. However, Oliver soon fell to a straight ball by turning his back to the ball, and was deemed B.B.W. (Buttock Before Wicket).

Chris Thomas then entered the arena, with fond memories of the last encounter, and proceeded to hit 20 off the first four balls he received (6, 4, 4, 6). This gruesome punishment of their opening attack carried on till Chris had scored a handsome 74, having hit six 6s seven 4, and surviving a chance early on.

Thomas was well supported by John Rawcliffe and Mick Fillerey, who was making his debut in first-class cricket. Fillerey was out trying to hook a good length delivery which hit the stumps. Mike Bellew went cheaply as did Faisal Suleman and Genghis Gulamali, but Garry Manning settled down and scored 47 runs with some attractive strokes and good running between the wickets. He was well supported by Francis Hughes (14) and Naresh Bhuva who scored 25 not out, and so by tea, Guy's had thundered to 207 all out.

Thomas and Bellew opened the attack for Guy's; Thomas was quick and wide, Bellew accurate with reasonable pace. The first wicket fell to Bellew in the sixth over, with a well-taken catch by captain Genghis diving to his left. The London were 10 for 1. Their third man then marched in smiling with confidence, his moustache bristling with anticipation of runs he was going to score. However, he was soon caught by Thomas, again off Bellew. The London wickets then tumbled rapidly, with some good bowling by Bellew and Bhuva; Thomas being unlucky to collect only one wicket. Bellew had 5 for 20, and Bhuva had 2 for 2, with Thomas and Suleman completing the attack.

Thus the London collapsed to 48 all out, and Guy's won by 159 runs, a thrashing which the London won't forget easily.

Team: Shiraz Gulamali, Tim Jennings, Jim Oliver, Chris Thomas, John Rawcliffe, Mick Fillerey, Mike Bellew, Garry Manning, Faisal Suleman, Francis Hughes, Naresh Bhuva.

TENNIS

The men's tennis team have recently played three friendly matches and won them all convincingly. The Law Society, Greater London Council and Medical Sickness Society teams all succumbed to Guy's teams appreciably strengthened by Tim Thurston, Rick Plowman and Jonathan Pringle.

We are still trying to play the Hospitals Cup semi-final match against St. Mary's but they seem to be taking desperate avoiding action.

There have also been two mixed doubles matches. Both were very enjoyable. We beat St. Thomas's easily but I haven't a clue what happened in the match against the London Hospital.

Andy Morgan.

GOLF

Guy's v. Charing Cross

A powerful team of the finest competitive sportsmen yet to be produced by Guy's . . . sorry, at it again.

Dave Fish 1, Mike Craigen ½, Stuart Matthews 1, Andrea Malizia 1, Duncan Walker 1, Paul Robinson 0—managed to win 4½ to 1½.

We got there an hour early at least and sharpened our putting behind the bar and conjured tall anecdotes on the practice putting green when the first of the opposition arrived (a known one handicapper) whom David had the fun of beating, despite having his partner whip 3 irons 20 yards past his drive, by 6 and 5. There is little more to tell except that Mike didn't actually win this time and our secretary has sworn his clubs aren't for sale any more.

The man of the match award goes to David for organising a square yard of

silver plate heaped with miscellaneous sandwiches and the longest sausages I've ever seen in the jovial atmosphere which ensured a return was immediately organised.

Our thanks go to Charing Cross (obviously old rivals of the future) Guy Palmer, team mascot, who joined in the refreshments, and Mr. Saunders of Sundridge Park without whom this would never have been possible.

Stuart Matthews.

Hospital Information

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PASS LIST

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R. N. Edwards

Diploma of Member in General Dental Surgery

P. J. E. Lang

A. A. Riley

P. J. Willard

UNIVERSITY OF LONDON

Ph.D.—Science

G. M. Cooke (Biochemstry)

Ms. D. A. Galbraith (Biochemistry)

BIRTHS

MAY—To Pamela and Christopher a daughter, Elizabeth Anne on June 28th, 1979.

AUCKLAND—On March 30th, 1979 at Freedom Fields Hospital, Plymouth, to Sabrina (née Donne) and Geoffrey, a daughter, Rebecca Joy.

DEATHS

SABINE—On May 26th, after a short illness in *Johannesburg, South Africa, Margaret* Wareham (née Morrow), beloved wife of Anthony, of Pinsett, Dukes Wood Avenue, Gerrards Cross, Bucks.

MARRIAGE

DAY—JOHNS on June 11th, 1979 at St. John's Netherfield, near Battle, East Sussex, Miss Caroline Helen Day, S.R.N., to Dr. Andrew Robert Johns, B.Sc., M.B., B.S.

CHANGE OF ADDRESS

APPLEBY—Mike and Nina, "Little Pendle", 215 Botley Road, Chesham, Bucks., HP5 1XD.

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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Commissioners for the Area Health Authority.

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Gazette Prints

The *Gazette* has produced full-size photo-facsimiles of three pen and ink drawings by Hanslip Fletcher of Guy's Hospital and its environs, on matt-finish high quality paper suitable for framing.

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Passim

In this month's "Gazette" we have tried to present some relevant information concerning the state of Lambeth, Southwark and Lewisham A.H.A. in the hope that opinion can have a rational basis in fact.

In all fairness to Health Minister Mr. Jenkin, it must be said that he is a man of method and of his word, for—by fiat—he has taken political expediency to its limits. Our Area Health Authority suffered under the levelling policies of a Labour administration because of the mistaken sums of Resource Allocation (*Passim*—July). These policies have been pursued under the Conservatives—ostensibly for the same reasons, but really because they further the economic ambitions of a government for which the cutting of public expenditure is a fundamental article of faith.

Of course, looking at the balance sheets alone, there are authorities who are less well off, but as the *Gazette* has been at pains to point out (*Passim*—May) we are not the rich from whom a government can take to give to the poor. Mr. Jenkin may content himself in his belief that the cuts will not cause patients to die (presumably disease sees to that) but the ugly fact is that life expectancy *is* already reduced (e.g. for want of early surgery and dialysis).

The effect that the closure of St. Olaves and other cutbacks might have upon patients is receiving full discussion in the national and local press. It is perhaps up to us to point out that the education of medical students in their clinical years would suffer in equal measure. As long as the Area and higher authorities are obsessed by the need to cut spending, rather than determining what is an adequate level of provision by full and frank discussion with all parties, our services and the morale of those who provide them will continue to be damaged.

Nobody holding the purse-strings seems to consider that our Area, the largest in the country, containing three major national teaching hospitals, is in any way a special case—but this fact is blatantly obvious to everybody else.

Yet cuts can be made.

Five years ago, a secretary, receptionist and part-time porter ministered to the needs of medical staff and patients in one small department at Guy's. Now, there are three secretaries, two receptionists and a full-time porter. The wives of senior hospital staff once advised decorators on new colour schemes and furnishing. Now, we boast our own full-time "design adviser"—with access to a pool of secretaries.

The right place to make cuts—the only ones which are unequivocally indicated—is in the burgeoning tiers of administrators, because many of them are unnecessary and engulf significant portions of the financial cake to feed their insatiable appetites for pompous inefficiency.

News in Brief

Guy's North Wales Dining Club

The Guy's North Wales Dining Club will be meeting at the Druid Inn, Gorsedd, Nr. Holywell, on 28th November, 1979. The Guest Speaker is Sir Cyril Astley Clarke, K.C.B., F.R.S., Past President of the Royal College of Physicians and formerly Professor of Medicine at the University of Liverpool. Any Guy's graduate is welcome. Further information may be obtained from the Secretary: Dr. T. M. Winstanley, The Croft, Bryn Goodman, Ruthin. Tel. Ruthin 2868.

Ladies Squash

Ladies squash practices will be held on Tuesday evenings from 5.00 p.m. until 6.30 p.m. Anyone interested should contact the Ladies Captain (Fiona Clark) through Jill Simmons on extension 2420.

M.B. Finals Results

In the light of last year's examination results (which were reviewed in a *Lancet* editorial) we have to report that this year twenty candidates out of one hundred and thirteen failed to qualify M.B. London. All those sitting for M.B. Cantab. passed.

These results, according to the Medical School, are worse than King's and rather worse than University College although they are near to the University average.

Guy's Guild Men

Our congratulations are due to R. D. Maile, Consultant Radiologist, who has been elected Upper Warden of the Worshipful Company of Wax Chandlers; and to W. G. Cross, Consultant Dental Surgeon, who has been elected Renter Warden of the Worshipful Company of Barbers.

George Cross was, in 1948, the first person to take—and to pass—the degree of M.S. in Dental Surgery (see *Passim* of the *Gazette* of 14th August, 1948), despite that degree having been instituted as early as 1910.

All change at the Bank

Our congratulations to Mr. R. C. Scriven (formerly Assistant Manager of the Southwark Street branch of the National Westminster Bank) on his recent promotion. He is to be succeeded by Mr. Southgate who, we are sure, will continue to help students in the same kind and understanding manner as has his predecessor. At any rate we hope to welcome Mr. Southgate in traditional manner at the Wine and Cheese party!

Appointment of Free Church Chaplain

Mr. Boorman who has been the Free Church Chaplain for over 16 years retired at the end of July. His successor is a Methodist minister Reverend R. Stephen J. Penrose, who took up his appointment on the 1st August.

Welcome to Guy's

The Editors heartily greet all the pre-clinical and clinical students joining us at Guy's this month. You enter a hospital with many fine traditions which is falling upon hard times!

We invite you to read the information and advice in our columns this month and make of it what you will. At the Freshers Fair on 1st October you will have an opportunity to meet enthusiasts from the many clubs and societies at the Hospital, and we hope that you will not be persuaded into joining them all! May we make a special plea, however, for the Sporting Clubs who are more than ever deserving of your support? In no area are our traditions more hallowed and glorious than in the field of sport, yet the gap between expectation and performance grieves many hearts. We hope for much from you!

Retirement of Dr. K. S. Maclean: Any of his past Registrars or HP's wishing to attend a farewell dinner on November 23rd please contact Dr. C. M. C. Allen, c/o Dept. of Neurology, Guy's Hospital.

Guy's Health District
Lambeth Southwark and Lewisham
Area Health Authority (Teaching)

District Circular
Number 46/79

COMMUNICATIONS WITH THE PRESS ETC.

Under a Direction issued on 1st August 1979 by the Secretary of State for Social Services, the South-East Thames Regional Health Authority is now performing the functions of the Lambeth, Southwark and Lewisham Area Health Authority (Teaching).

Instructions have been received from the Regional Health Authority that staff of the Area Health Authority (Teaching) should not communicate with representatives of the Press and other media regarding the financial position of the Area Health Authority (Teaching) or the implications of this position so far as services provided by the Area Health Authority (Teaching) are concerned.

All members of staff are asked to comply with these instructions. Representatives of the media may be referred to the Public Relations Department of the South-East Thames Regional Health Authority.

DISTRICT ADMINISTRATOR

3rd August 1979

Guy's Health District

Lambeth Southwark and Lewisham
Area Health Authority (Teaching)

District Circular

Number 47/79

COMMUNICATIONS WITH THE PRESS ETC.
FURTHER GUIDANCE

Further to District Circular No. 46/79 and following the appointment of Commissioners to perform the functions of the Lambeth, Southwark and Lewisham Area Health Authority (Teaching) revised instructions have been received from the Chairman of the Commissioners.

As a result of these instructions the following points are made:-

1. District Circular No. 46/79 is withdrawn.

2. The Commissioners will handle public relations matters regarding their actions and policies through their staff at Area Headquarters.

3. Communications with the Press at District level will be dealt with as hitherto. The normal point of contact for the Press and other media will continue to be Sector and Unit Administrators.

4. Members of the District Management Team will be glad to provide information and advice regarding public relations matters and trust that as heretofore, and particularly at this time, they will be kept informed about any proposed publicity concerning the District's affairs.

DISTRICT ADMINISTRATOR

13th August 1979

Escape the spending cuts

Dr. Julian Stokes (29), a Guy's graduate, is leaving Greenwich to take up a post as Senior Medical Officer on the Solomon Islands. This appointment has been supported by the Crown Agents in a scheme which provides British experts to work in developing countries. Our best wishes to him, and to his wife Judith, a qualified nursing officer.

What the doctor ordered

Peter Higgins, Professor of General Practice at Guy's, and vice-chairman of S.E. Thames Regional Health Authority, suggested a possible way to save A.H.A. money in a recent edition of *Pulse*.

He suggests that hospitals tend to hang on to patients that G.P.'s ought to manage, and that "about half" of G.P. referrals to medical outpatients do not require specialist attention.

One hopes the Commissioners are listening.

Obituary

PROFESSOR GILBERT STEAD, M.A., D.Sc., F.Inst.P.

Professor Stead, who died on 5th July at the age of 91, first came to Guy's in 1923 as Reader in Physics, a part-time post which he held until 1938 when he was appointed to a University Chair of Physics. He retired in 1953, to become Emeritus Professor. He was also Honorary Consulting Physicist to the Hospital. His connection with Guy's thus lasted for some 56 years.

The *Gazette* for October, 1953, devoted twelve pages to Stead's retirement, including personal appreciations from two senior members of the Medical School and Hospital staffs respectively, a verbatim account of his farewell lecture, entitled *Then and Now*, and an editorial comment. What was said of him then was very true. K.S. wrote *" Stead was obviously a fine teacher, . . . He was readily accessible and . . . contrived to know a great deal of his students' personal character—and foibles. Imperturbable, quiet voiced and gentle mannered, but with an air of command that did not invite disturbances, Gilbert Stead set out to qualify the 3,000 or so medicals who were to pass through his hands in the next 30 years—and remember him with much affection."* The warmth of this affection, of which he never seemed wholly aware, sometimes showed itself in unusual ways. For instance, they put him in a Residents' Play as a crew-man in a space-ship; and when he was sent by the University of London to examine at the University of the West Indies he was greatly

surprised by the number and gaiety of those who went to Paddington Station to bid him *bon voyage* and to offer gifts.

Among the gifts was an autographed copy of his book *Experimental Physics,* "so that he would not forget" the subject. This book had first appeared in 1923. After 11 editions, the last twice reprinted, it is still selling and has recently assisted its publishers to receive one of the 1979 Queen's Awards for Export Achievement. When the conversion in the text from c.g.s. to S.I. units became necessary, despite failing eyesight (he was then over 80) Stead himself re-wrote the difficult section on magnetism, now based on a different set of basic principles, in his usual clear and immaculate style. An elementary text-book still "going strong" after 56 years must surely be a record!

Stead's other great contribution to medical teaching was in the field of radiology. Soon after the First World War Dr. A. E. Barclay, in Cambridge, pioneered the first (Cambridge) Radiological Diplomas. In 1924, Stead became University Lecturer in Physics as Applied to Medical Radiology and took over the lectures on radiological physics at the Cavendish Laboratory. Later, of course, he gave similar courses at Guy's. Hundreds of post-graduate students from all over the world attended these lectures; and many of them have been examined by him—firmly but sympathetically—at Queen Square. Some of them have themselves become distinguished in this field and remember him with gratitude. The British Institute of Radiology elected Stead as their President for 1947/48 and later invited him to give the annual Sylvanus Thompson Memorial Lecture in 1959. This was typically unusual. Aided by Mr. Kenneth Twinn, he transported to and re-erected in the Institute's House in Welbeck Street, apparatus contemporary with Roentgen and used it to repeat as closely as possible the original discovery of X-rays and to demonstrate their nature to an enthusiastic audience *(Brit. J. Radiol.* 1959, vol. 33, p. 425).

Stead's academic colleagues knew well, as one of them put it, "how shrewd he has always been in discussion, how wise in counsel, and how temperate in judgement". He was a Governor of the Medical School from 1948 to 1953. He was Chairman of a University Board of Studies and a member of many committees. It was said that *"whenever there was a little bit of difficulty"* one way to a solution was to *"have a sub-committee and put Stead on it."*

Stead never envisaged his work at Guy's as merely teaching. His vision was that physics could and should be able to contribute to many aspects of medicine; and his struggle to achieve this against great difficulties, was vividly described in his farewell lecture *(Gazette,* vol. LXVII, p. 375).

In that issue the Editor wrote "we do not intend to give the impression that we are saying goodbye, for we have good reason to believe that we shall often have the pleasure of seeing him in and around the Hospital and Medical School." How true that proved to be! Stead rarely missed a function which enabled him to meet old friends and he thoroughly enjoyed exhibitions and "open days". His last appearance was at the Fison Memorial Lecture in 1978.

We mourn a distinguished colleague, who was a true friend, respected and loved by many, and a loyal Guy's man.

C. B. A.

GROUP CAPTAIN JOHN BEAUMONT GREGOR, M.R.C.S., L.R.C.P.

Jack Gregor died in hospital in Alderney C.I. on 19th July. He was born in Ilford in 1895 the son of a Scottish doctor. Soon after his birth the family moved to Falmouth where Jack spent his youth and where he attended school. A life-long sufferer from migraine his father considered him unfit to do medicine as he so much desired but eventually he persuaded his father and entered Guy's Hospital Medical School on 1st January, 1915.

In February 1916 he and two friends left Guy's to join the Royal Navy and he served in the Hospital Ship *Plassy* as sick berth attendant and later in mine-layers as Surgeon Probationer and Surgeon Sub-Lieutenant. On demobilisation he returned to Guy's to complete his medical training and he was house physician to Dr. Herbert French.

He made one journey as ship's doctor to Australia and New Zealand and on his return to London he happened to pass Adastral House one day, went in and joined the Royal Air Force, a decision which he never regretted.

Whilst serving in Iraq he met and married an R.A.F. nursing sister. Later he served in Malaya, Egypt and Malta and during war because of indifferent health in the U.K. and after the war in Germany.

He retired from the Royal Air Force in 1949, and soon after his wife died. He worked at this time in an administrative capacity in the Sir William Dunn School of Pathology in Oxford.

In 1956 he visited Alderney and liked it so much that he decided to resign. On his way back to Oxford he stopped briefly at Southsea to see a friend whom he took out to dinner and the next day she had a letter from him with a proposal of marriage.

So Jack and Phyllis moved to Alderney where they lived in rented accommodation for some years and then built themselves a very charming house. Jack was not to enjoy his new home to the full for long. After a series of successful operations he had a stroke which left him hemiplegic and aphasic for almost 10 years.

His long survival is undoubtedly due to the loving care which Phyllis gave him all those years and for the last few years she was greatly helped by an old Guy's nurse who had also retired to the island. It was only when Phyllis had to go to hospital herself that she agreed for him to be admitted some weeks ago.

Jack contributed the chapter on the Balloon Command to the *Medical History of the Second World War*.

W. G. T.

DR. EDMUND TRAFFORD CLIFTON

Edmund Trafford Clifton died in his home in Pretoria on the 18th July, 1979, aged 79 years. He was at Guy's during the twenties and was a rowing blue. He was Dr. Beddard's last House Physician and after a few years in various London Hospitals came to South Africa to an appointment with Sub Niger Gold Mining Company on the East Rand where his great friend Leslie Sheffield Williams was at that time senior medical officer.

When Leslie Williams died many years ago, Cliff, as we knew him, succeeded him as Chief Medical Officer of the large and important mining group then called New Consolidated Goldfields. Cliff devoted his medical career to the thousands of black mine workers of his group and looked after them exceedingly well. Apart from this he was a dedicated worker for the South African Red Cross being Chairman of the Southern Transvaal Region for many years, and later the Chairman of the National Executive Committee of the Red Cross. There will still be a few alive who knew him. He was a great credit to Guy's and a fine and lovable man. He will not be forgotten here.

L. R. B. B.

D. W. GEIDT, M.A., D.M., B.Chir.

Dr. David Geidt died in peace at his home overlooking the Exe estuary on 14th April, 1979.

Born in India in 1906, the son of a High Court Judge, he was educated at Wellington College, Merton College Oxford, and Guy's Hospital —where he was contemporary, amongst others, with Cyril Clarke and Hedley Atkins. Qualifying in 1932, he held several house appointments at Guy's before entering general medical practice in Exmouth, Devon, in 1936. He joined the R.N.V.R. in 1940, and served in various ships in the Mediterranean, Atlantic and Arctic theatres of operations, and was involved in the offshore shelling of the French coast by *H.M.S. Erebus* in June 1944. He was appointed G.P. Specialist in Anaesthetics at Exmouth Hospital in 1948, finally retiring from a long and honourable medical career in 1973 amongst his many friends in Devon.

C.A.C. writes:

> "Hefty, flaxen-haired, immensely popular, loving his $3\frac{1}{2}$-litre Bentley and always ready for a party—these are my memories of David in the early thirties when we were undergraduates together at Guy's. But he had his serious side and wrote a first-class D.M. thesis on Glucose Tolerance Tests in patients with Gastro-enterostomy—showing that many of them had diabetic curves. Later, he never missed a Guy's biennial dinner, and we always sat next to each other and 'tired the sun with talking'."

David was a man of parts: a bon viveur with a discriminating knowledge of wine, a bird-watcher of distinction, a sportsman—especially a yachtsman, a gardener and a dedicated family man. He enjoyed life to the full from his earliest undergraduate days, and his family still treasures a Certificate of Thanks from the Chairman and Manager of the London United Tramways Company for his volunteer tram-driving during the General Strike of 1926; it is said that he drove the tram with the same panache as when driving his Bentley.

Clubs' Union News

Once again, to all the Freshers, welcome to the gigantic, confusing, overawing Guy's campus! This certainly was the way the place seemed to me for my first few weeks here. By now you will have received the traditional exhortation from the Dean which is supposed to encourage you to attend to your studies before everything else. You will also have been exposed to a rather less articulate but probably more welcome address from me in which I said "Whatever you do don't work all the time". The conflict between what is an appropriate devotion to duty and what is excessive and counter-productive is one which you alone will be able to resolve. This is one of the major challenges of University life, the privilege and enormous responsibility involved in ordering your life completely for the first time. Most oscillate from hedonism during the mayhem of Freshers week to a scholar, and back again. It has certainly taken me a long time to find anything like a balanced approach.

How long then are you, to use what I always think is a perjorative term, a Fresher? I think that is up to you, for the more you participate in the clubs and life of the place the quicker you will get to know people outside of your particular year. When that starts to happen and you contribute to any portion of our communal existence, whether in a society club or on the sports field, you stop being a Fresher.

The *Gazette* has an important role in this hospital as it attempts to bridge the communication gap that exists not only between present and past Guy's students, but also between all of the staff of the School and Hospital who read it. The *Gazette* has a venerable reputation in battling against the perennial problems of communication and continuity, a crucial function that once again flourishes in proportion to the quality of the input.

This coming term is one which always has a very heavy sporting programme as the competitors adjust the final compositions of the teams. As usual, during the term there will be Inflams in the Bar, Dances, Quodlibet debates, Charity lunches, Music and Theatre Club productions, as well as a Film presentation every fortnight.

The major campaigns for the University of London Union for this year are likely to be opposing the Government's policies on Overseas Students, and the cutbacks in University funding and hence student numbers. How these issues will affect Guy's is not yet clear but if any government is going to galvanise students into positive concerted action I think it will be this one.

The local Area Health Authority is of course no stranger to financial cutbacks, but their problems are thoroughly explored elsewhere in this journal. Also on a parochial note preparations are well in hand now for the 1979 Snowflake Ball which will be held on Friday, 30th November. If people are interested in helping as decorators, waiters, bar staff and so on for the customary reward of free entry would they please contact me as soon as possible.

A few days ago Philip Razzell, the Chairman of S.M.E.C., and I,

met the Sub-Dean, to talk about what could be done to improve the quality of career guidance available for medical students. As a result the library is likely to buy some books on the subject and as a trial the Student Medical Education Committee (S.M.E.C.) will be invited to arrange a seminar. One idea might be that this should be held during the block pathology course or the introductory course to the second clinical year. Speakers from various fields of medical employment, such as the armed services and the Medical Research Council, will be invited to deliver a talk on their discipline and answer your questions. If successful I would like to see the scope of the venture broadened and possibly tied in with a personal tutor system for the clinical years.

Chas Newstead, President.

Freshers' Section

Welcome to Guy's from the Deans

J. C. Houston, Dean, Guy's Hospital Medical and Dental Schools

The choice of career and where to study for it are among the major decisions in life, yet I suspect that for many people the processes of thought which lead to these decisions are as insubstantial and illogical as those which subsequently lead them into matrimony. This does not mean that they make the wrong choices, or that those who appear to know exactly where they are going and why are necessarily more likely to succeed. "Why do you want to be a doctor?" is often asked by those who interview for medical school places; but the interviewer is more likely to be interested in how the question is tackled than in the actual reasons given. Lacking any family background in medicine and having done no science at all, I was within a fortnight of leaving school when it suddenly came to me that I would like to be a doctor; and when apprised of this fact my Headmaster, instead of blowing his top at this belated change of plans, simply said "If you're going to be a doctor you'd better go to Guy's". That's why I'm here. Many of you, no doubt, could give much better reasons for being here. Very few, I venture to suggest, will not look back on their arrival here as one of the happiest events in their lives and it is with unusual confidence in the accuracy of this prognosis that I bid you all welcome as members of the Guy's family.

J. C. Houston.

Professor R. D. Emslie, Dean of Dental Studies

To the Fresher the external view of the Dental School at the top of the Tower may seem rather forbidding, very different from the friendly, if slightly dilapidated gentility of the pre-clinical departments in the Medical School. This spacial separation of the facilities for clinical and

for pre-clinical work is indeed in some respects unfortunate, but is almost inevitable in our combined medical and dental schools with pre-clinical departments serving both schools. It does render difficult the integration of pre-clinical and clinical aspects of the same discipline which is educationally desirable.

At Guy's we attempt to overcome this handicap by the appointment of some dentally qualified staff in the pre-clinical departments and the presentation of lectures and demonstrations by clinical teachers to students in the 2nd B.D.S. course. Pre-clinical students may also be invited to participate in clinical trials and this is an excellent way of getting the "feel" of the dental school at an early stage. The excellent library on floor 27 of the Tower is open to all dental students and others, and may provide a quiet haven for study, with unsurpassed views, when the Wills Library is crowded.

Of course, another way of getting the "feel" of the dental school is to attend for treatment as a patient. There is no better way of discovering how important it is to be kind and considerate to patients, and we like to think that this is the hallmark of a Guy's-educated dentist.

I welcome you all to the Guy's community!

Now you're at Guy's . . .

Professor Anthony Diplock, Department of Biochemistry and Chemistry

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In welcoming new students to Guy's it is often difficult to appreciate how bewildering the experience of starting the medical or dental curriculum can be to the newcomer. Gone are the days of sharp division into "Pre-clinical" and "Clinical" parts of the course and instead we try to make the educative process a continuum between the initial basic science training and the parts of the course that are more obviously about the business of being a doctor or dentist. In designing curricula, therefore, our primary concern has been to interest students in the applicability of their basic science course to their chosen profession, rather than to serve up scientific facts in isolation from the practice of medicine and dentistry in a manner which is unpalatable to the student, who cannot see what the scientific discipline has to contribute to an understanding of diseases, and to the discovery of the manner in which they may be cured.

Now that the pressure of working for your "A" levels is off and the uncertainties of the U.C.C.A. system are behind you, you may have a certain feeling of anti-climax now that you have arrived at the Medical School of your choice. Most students settle in their new environment quickly and easily but each year there are some who have difficulty in adapting to their completely new environment. If you do feel unsettled you will find that many members of the Staff here may be able to find a solution, if you discuss your difficulty with them.

Your teachers are here to help you learn, and the process of education is a two-way one involving active participation by both teacher and pupil. An eminent physiologist was once asked to define a lecture and,

after some thought, he said that it was "the transference of the content of one person's lecture notes into the lecture notes of a number of others, without the material passing through the minds of any of the participants'. The Staff at Guy's will certainly endeavour that their part of this statement will be untrue; it is up to you to see to it that your part is untrue also.

Physiology

Chris Wolff, Department of Physiology

Physiology is a subject which attempts to understand how the body works. The staff, in their research, try to unravel some of the complexities of body mechanisms and then, in their teaching give as clear as possible an exposition of current views on body function. Students vary in their initial reaction to Physiology, from delight in finding that problem solving helps in its understanding, to bewilderment and frustration if they expect a subject that simply involves memorising facts.

Students in the basic medical science and dental courses are given tutorials in small groups every week during term time as well as lectures and practicals. The medical students are also given multiple choice questions as a teaching aid to supplement the basic framework of lectures. Near the end of the first year the medical students work on practical projects in several groups, often testing new hypotheses experimentally.

A few students are given the option of continuing with an honours B.Sc. course following their basic science course.

Pharmacology

Professor Roy Spector, Department of Pharmacology

I am grateful to the *Gazette* for this opportunity to welcome new students to Guy's. We in the Pharmacology and Clinical Pharmacology departments feel particularly close to the students in that our contact with them extends from the first to the last days of the M.B. course (and in some cases much beyond this). The orientation of all our pharmacology teaching at Guy's is towards medicine—and even in the earliest lectures the therapeutic implications of drug action are considered.

The Basic Medical Science part of the teaching is integrated where possible. That means when you observe the gross anatomy and microscopical structure of the stomach and learn about the physiology of gastric secretion and motility, we try to fit in sessions dealing with drugs which physicians and surgeons use in treating diseases of the stomach.

I hope you will enjoy the stimulus and challenge of integrating all of these subjects in your own minds.

Pathology

Dr. D. R. Turner, Reader, Department of Histopathology

Pathology is the study of disease processes and as such, can be viewed as an academic pursuit in its own right. Much of the experimental pathology which has been carried out, deals with basic disease mechanisms such as inflammation, thrombosis, infarction and neoplasia. It could be argued that these aspects of medicine, though interesting as processes which can occur in the human organism, are not essential to the treatment of the sick which could be done on an empirical basis. However, from this basic core of general pathology, a large number of offshoots of knowledge have developed which enable us to diagnose diseases in individual patients with precision. In order to do this we may require blood or other body fluid, some pus draining from an infected site, or a piece of tissue obtained by needle biopsy or during the course of a surgical procedure. Accurate diagnosis allows the clinicians to study the natural history of disease and the effects of therapeutic regimes on specific categories of patients.

The clinical examination of the patient can often narrow down the diagnostic field considerably but usually some pathological investigations are necessary for accurate diagnosis. I believe this is still the usual approach in this country although in the U.S.A. there is a marked tendency to request a whole battery of tests before the patient has been examined clinically. To a lesser extent this problem has crept into this country as well. One of the modern problems of the collection of pathological data is that the blood cell counting machines and chemical auto-analysers are capable of producing a vast amount of data from a single sample of blood or body fluid. There is therefore a danger that the important result may be lost in a sea of irrelevant information. There is also the problem that if you do enough tests for no good reason, then you will occasionally come up with some abnormal results. It is tempting to investigate these further, with the result that much time and money may be wasted.

It can be seen that pathological studies can be a valuable adjunct to clinical investigation. Much time and money can be saved by the intelligent uses of pathological resources. Thus the clinician needs to supply a brief summary of the case with the specimen and preferably should indicate what question he is asking. Indeed if he is unable to do this, the request for pathological studies should probably be refused. In return the pathologist should supply an opinion with the minimum of delay. This may be difficult if the request form has been signed illegibly and does not carry the name of the consultant in charge of the case, or the patient's ward, as is often the case! I hope that the new intake of students are sufficiently concerned about medicine in general and their patients in particular that these faults will disappear in future years.

Your Psychology Course

John Weinman, Unit of Psychology Applied to Medicine

Those of you who are earnestly expecting the Psychology course to provide an instant personality assessment kit are in for a disappointment. The task of understanding the vagaries and complexities of human behaviour is not a trivial one and simple solutions are just not available, despite the impression given in the writings of psychology's more notorious popularisers.

The B.M.S. course has two broad aims. Firstly there is an attempt to provide an outline of aspects of psychology which can be applied to areas of medicine. This includes an account of basic psychological processes (e.g. memory; emotion, etc.), the links between brain mechanisms and behaviour, the nature of individual differences in behaviour and of social interaction. The second aim is to deal with areas of medicine in which an understanding of human behaviour can play an important part. Thus this covers such topics as psychological reactions to illness, handicap and hospitalisation, doctor-patient interactions and the role of phychological factors as aetiological agents and in treatment. By encompassing these two broad themes it is hoped not only to convey something of the rigour and scope of current psychological approaches but also to provide insights into the world of the patient.

The Unit of Psychology also offers a number of places to students wanting to do an intercolated B.Sc. course in psychology or in combination with other related subjects such as sociology, neuroanatomy and neurophysiology.

Your Sociology Course

David Armstrong, Unit of Sociology as applied to Medicine

Medical Sociology is taught to three groups of Guy's students:

(a) A 40 hour course is given to the preclinical students in their 6th B.M.S. term. The emphasis of the course is on the various social factors which affect how people come to use health services and how they respond to treatment. This includes social factors in the aetiology or organic and psychiatric disease and in the delivery of health care.

(b) Dental students receive a short course in their first clinical year on the relationship between social factors and attitudes and behaviour towards dental care as well as the problem of assessing and providing for dental need.

(c) A variety of course units in medical sociology are offered on an inter-collegiate basis to those students satisfactorily completing their B.M.S. course.

The Questions You Ask Us

JEAN FARMER
Wills Librarian, Guy's Hospital Medical and Dental School

How do I find a book in the library?

The card catalogue, opposite the issue desk, is arranged in author and subject sequences. On the top right-hand corner of each card are letters which tell you where books are located: eg REF—Reference, S.L.C.—Short Loan Collection, BME—the section on Anatomy (pre-1979 titles), QT/104—recent books on Physiology. The library is in the process of changing its classification scheme and recent purchases are filed in a separate sequence.

What are "Short Loan" books? (see above)

These are the books in greatest demand, mostly current textbooks. They can be borrowed overnight or from Friday to Monday.

How can I find the most up-to-date book the library has on the subject in which I am interested?

The subject catalogue is arranged in alphabetical order of subjects with the most recent books on each subject first.

How many books can I have out at once?

As many as you like within reason.

Do I have to have my reader's ticket to borrow books?

Yes. Also, since you are responsible for all books issued on your reader's ticket, if you lose it please tell the library staff so that a check can be made.

How long can I keep a book out?

Four weeks, except for Short Loan books. If another reader wants your book, however, you must return it after a week.

Can I renew a book I have without coming to the library?

Short Loan books must be brought back the next day, and will be renewed only if there is another copy available. Otherwise, provided that another reader does not want it, a book may be renewed by telephone.

(Wills Library extension 3374; Dental Library extension 2805.)

Can I pass on a book I have from the library to a friend?

No, because you are responsible for a book as long as it is out on your ticket.

What should I do with my book when I bring it back?

Hand it to the library staff member at the issue desk. Don't just leave it on the desk or on the book trolley nearby.

The book I want is on loan to someone else. Can I reserve it?

Yes, ask at the issue desk; you will be sent a card when the book is ready for you.

Can I obtain a book which is not in the library?

Yes, most books not in the library can be borrowed for you, generally from the British Library. These "interlibrary loans" are free to undergraduates if their tutor countersigns the request form.

I want to photocopy my notes. Can I do that in the library?

There is a photocopier in the corridor outside the library. To operate it you need a key counter, which you may obtain from the issue desk. The cost of photocopies is 5p a sheet.

I am revising for exams and would like to see some past papers. Are these available in the library?

Final MB, BS papers and MCQ books are kept in the library for consultation. The Medical School Office holds reference copies of BMS papers.

The library is very crowded. Is there anywhere else I can go to study?

There are study places on the ground floor of the Gordon Museum, which is open from 9 a.m.—5 p.m., Monday to Friday.

I think that the periodical I want is in the Anatomy Department library. Can you confirm this and may I go and read it there?

Periodicals held in departmental libraries in the School and Hospital are recorded in the periodicals holdings list in the library. Departmental libraries may be used for reference, but please ask permission from the Head of Department.

I have heard about the new computerised information retrieval services in medicine. Are these available at Guy's?

Yes; ask the library staff for more information. Demonstrations can be arranged for groups of students.

Can I borrow books from the University of London libary?

Yes, all students may use the University library at the Senate House. Application to join should be made at the registration desk in the entrance hall on the 4th floor of the Senate House. (Proof of student registration is required.) Ask the library staff for more details.

Can I arrange to use the university library in my home town during the vacation?

Yes, ask the library staff for a Vacation Reading Card.

If you have other questions, please ask the library staff—they are there to help you.

That Was The AHA(T) That Was!

by Professor J. A. D. ANDERSON, Department of Community Medicine, Guy's Hospital

In August Secretary of State, Patrick Jenkin, suspended the Chairman and members of the AHA(T)—that is the Lambeth, Southwark and Lewisham Area Health Authority (Teaching)—responsible for Guy's Hospital and its Health District. This occurred after a meeting of that Authority at which there was a majority vote against making the addi-

tional cuts in expenditure required to conform with the budgetary allocation of £138,000,000 for the current year. At first glance this might be seen merely as an act of defiance against a Right Wing Government by a caucus of Left Wing councillors renowned for their care-free capacity to spend other people's money. Credence could be given to this shallow view by the immediate indications of solidarity by spokesmen for the Health Service Unions, whose endeavours in the field of human suffering during the previous year may even have contributed to the fact that the Minister of State concerned is currently a Tory.

Need for a Budget

Health services require special buildings, complex instruments and skilled manpower to meet the needs of the public, and all these cost money. They also make demands on the nation's pool of intellectual resources and technical expertise. Unfortunately, there is neither unlimited cash for materials and training nor for that matter is there an infinitely large cohort of potential experts. In other words, our resources for the care of the sick and prevention of disease are finite.

There must be few people who die and almost none who are admitted alive to hospital for care in their last illness who could not have their lives prolonged by the use of some additional therapeutic procedure. For most patients these prolongations would be of short duration and could even be distressing for both the dying and their relatives. Nevertheless, if no account is taken of the quality of life among the survivors it would be possible to delay the average age of death—albeit for a matter of hours or even days—providing extra funds are available to meet the cost of the additional therapy. It is easy to point to the folly of perpetuating life by artificial means in a patient whose brain is little more than liquid pulp. By way of contrast, the successful conquest of subacute bacterial endocarditis by antibiotics and cardiac surgery for selected patients with congenital abnormalities have brought about both improved life expectancy and a higher quality of living to the survivors. The difficulty is that there are extensive grey zones between these two extremes where it is necessary to assess priorities.

Those concerned with health care can properly lobby in favour of increasing resources for their budget; equally it is natural for those with special interests to canvas for their specialty and for the staff of teaching hospitals to argue their case and to be supported by civic representatives from their local boroughs. However, it must be appreciated that every £5,000,000 spent by the AHA(T) means that if the Region is to keep within its budget then funds available for other Areas such as Kent and East Sussex will be reduced by that amount—a sum roughly equivalent to the salaries of 1,000 home nurses who could make an important contribution to home care for the elderly on the *Costa Geriatrica.*

Obviously if all Areas overspend then the Regional budget will be exceeded, thus depriving other Regions, and if all Regions overspend then the National Health Service will exceed its budget and other services such as education, Social Security and housing, to name but a few, may have to be cut. It is true that such cuts could be avoided if the national income were increased, for instance, through taxation but

this does not seem to be a very practical solution since it was the increase in VAT which was one of the factors leading to the financial confrontation between the AHA(T) and the Secretary of State.

Most people who give the matter serious thought accept that there must be some budgeting in relation to health services though people with different ideologies take opposing views on how to distinguish the health needs of the public from demands for care and balance these with the available resources. Thus pay beds, prescription charges and ward closures are high on the list of controversial topics. As things stand at present, the allocation of funds is vested in Parliament and the policy of successive Governments in the 30 years since the start of the Health Service has been to allocate a percentage of public funds tending to vary between 4% and 6% and currently estimated at 6.7%. The fundamental challenge is whether a political promise of free health care for all demands is in any way compatible with a budgetary policy. Perhaps a more honest attitude in this respect by the Central Government might lessen the tendency for local factions to feel that they must try and resist budgetary control.

The Role of the AHA(T)

Since 1974 the National Health Service in England has been organised on the basis of three administrative tiers. The Department of Health and Social Security (DHSS), Regional Health Authorities (RHA) and Area Health Authorities (AHA—or in the case of Areas with teaching hospitals AHA(T). Funds available for each Region are decided by DHSS according to a formula evolved by the Resource Allocation Working Party (RAWP) based on such factors as the size, age distribution and standardised mortality ratio of the Regional population. In turn, the RHA conducts a "mini RAWP" and allocates funds to the Areas within its jurisdiction. Most Areas are subdivided into Districts each with a District General Hospital or group of hospitals but the extent to which responsibility is delegated to the officers of the District Management Team varies; in the case of Guy's Health District delegation is considerable but the AHA(T) remains responsible financially to the RHA and thence to the Secretary of State. The question is (and many people are asking it): *Is the intermediate tier either necessary or desirable and would it not be better to establish autonomous District authorities—at least as far as the teaching hospitals are concerned?* However, even if this were done it would not reduce the need for budgetary restraint but at least it would reduce by one the bureaucratic tiers through which the budgeting processes have to operate.

Members of RHA's are appointed by the Secretary of State as are the Chairmen of AHA's and the majority of members of AHA's are appointed by the RHA; the other big source of membership of the AHA(T) is from the councils of the three London boroughs with which the Area is coterminous–Lambeth, Southwark and Lewisham–and from which the AHA(T) derives its title. Since the majority of members of the AHA(T) are appointed by Region and the members of the RHA are themselves appointed by the Minister it can be argued that members of the AHA(T) have an obligation to carry out the Minister's wishes in terms of conforming to his budgetary allocation. However, the members of the AHA(T) which represent local boroughs have an obligation to their own con-

stituents and this may be in conflict, at least according to their interpretation, with the budgetary allocation and the AHA(T). For example, elderly and chronic sick patients can only be discharged home if there are sufficient supporting social services from local authority sources to implement such a policy; if all the elderly were retained in hospital this would reduce considerably the demands for social services within the local authorities. It follows, therefore, that a further question must be asked: Is it feasible to expect councillors of a local authority to be compelled to conform to the budgetary constraints imposed by the RHA? At least for the present, AHA(T) members have a responsibility and some would argue that those members who feel they cannot work within these constraints should resign rather than defy the Minister. On the other hand, it seems unreasonable for the Secretary of State to impose additional constraints on the AHA(T) (as for instance salary increases and extra VAT) and expect them to be absorbed into an existing budget at short notice.

As far as the law is concerned the Secretary of State can suspend members of an Area Health Authority if it is felt that they are not running the Health Service appropriately. He can then appoint commissioners to manage the Service and this is in fact what has happened as far as the Lambeth, Southwark and Lewisham AHA(T) is concerned.

The Role of a Teaching Hospital

Teaching hospitals have three main commitments. First they act as District General Hospitals providing secondary medical care for their population. In the case of Guy's this is North Southwark and part of Lewisham, and in no way could the comprehensive resources of a hospital such as Guy's be justified if the responsibility was merely for that limited population—particularly as there has been a decline in numbers during the past decade.

The age structure of Guy's population is similar for that of England but there are fewer elderly than in other parts of the South East Thames Region, particularly the South Coast. On the other hand there is much greater social deprivation in the District in terms of overcrowded housing, substandard sanitation, one parent families, etc., than in the rest of the Region. At present the only account taken of these disadvantages by RAWP is the fact that the standardised mortality ratio is raised in people who are socially deprived, so there is considerable debate as to whether sufficient account is made of social factors in the RAWP formula when one considers long-term non-fatal illnesses.

Whether or not there are grounds for claiming that Guy's District requires more than its fair share of the cake because of social problems, there is little doubt that in respect of the second responsibility of the teaching hospital there is strong justification for an extended budget. Teaching hospitals provide tertiary care—that is they handle cases which are too complex for ordinary District hospitals—so called Regional responsibilities. They also have highly specialised units which have supra-Regional responsibilities and Guy's is no exception. Clearly extra-budgetary allocation must be made for such responsibilties since there is no question of the services offered by such highly specialised departments being offered only to the population of the Guy's Health District.

There is, however, an additional problem in that most Regions in the country have only one teaching hospital whereas South East Thames, like other Thames Regions and Trent, has more, and in the case of South East Thames these teaching hospitals are all concentrated in the top left hand corner of the Region between Denmark Hill and the Thames. As far as health services are concerned it would have been a much happier arrangement if the three large teaching hospitals had been located at Canterbury, Brighton and Tunbridge Wells.

The third function of teaching hospitals is of course to teach, and in this connection doctors employed by the National Health Service spend some of their time teaching students, while doctors in the Medical School contribute to the work of the hospital by providing clinical services. Up to a point these balance each other, but in practice the clinical service provided by the academic staff is likely to exceed the teaching commitment of the hospital doctors because there are on the staff of the School not merely doctors salaried through the University but also doctors with higher educational fellowships, or working on research projects with salaries met by various foundations. A high proportion of all these groups are anxious to gain clinical experience and therefore offer their services readily to the hospital. In terms of medical salaries this additional manpower makes no demands on NHS funds but substantial extra costs arise from requests for laboratory tests and X-rays together with the treatments recommended which are often innovative and expensive. Having said this it would clearly be disastrous for medical education at both undergraduate and postgraduate levels as well as for research if these activities were unduly curtailed. It is generally accepted, therefore, that allowances must be made in respect of the teaching hospitals and the budget of its AHA(T) for these expensive activities in relation to the health care offered by the extra pool of medical manpower.

Quite apart from the expenses incurred in terms of diagnostic facilities and therapy by Medical School staff doing clinical work in a teaching hospital, there is an additional problem that extra medical staff tends to result in shorter waiting lists for out-patient appointments. Thus, the patients attending clinics at Guy's who have travelled from as far afield as Folkestone, Sevenoaks and Croydon may do so because the waiting list at their local hospital is unacceptably long rather than because their condition is so complex that the extra resources of a teaching hospital are necessary. This would seem to be the wrong reason for patients attending a centre of tertiary care; rather it would be an argument favouring the provision of extra resources in the peripheral hospitals. An extra complication exists in that large numbers of patients resident in other areas of the Region pass the gates of Guy's every day going to and from their place of work and find it convenient to attend as outpatients.

These then are some of the complex issues that underly the recent act of insubordination by the AHA(T). The tragedy is that complex issues seldom have a simple solution and it is highly unlikely that the Commissioners appointed by the Secretary of State to do his bidding will be able to reduce expenditure within the Area by the requisite millions

before the end of the financial year. Indeed, there is a danger that attempts to reduce expenditure will lead to a waste of much time by many professional people and this is itself an expensive commodity. The outcome could be disillusionment even by those who accept that some budgetary constraints are necessary.

The crux of the matter would appear to be that a teaching hospital complex receives long term funds from two Government sources—the D.H.S.S. and the U.G.C.—each the responsibility of a different department. In the past each has been prepared to accept that some funding is needed for long term research and development without looking too closely at demarcation limits. However, at a time when public expenditure is being cut each appears to be planning on the basis of meeting immediate needs in the misplaced hope that long term developments will continue to be funded by the alternate source. If this double ostrich act continues it will not be just the AHA(T) that will pass into limbo. The decision as to whether or not the country can afford an institution such as Guy's in relation to health care and medical education is a matter which requires consideration by a supra-Departmental body rather than leaving the issue to be resolved by a sordid squabble between different tiers of Health Authority whose *raison d'etre* is to ensure adequate provision of routine health care. One such body—the Royal Commission on the National Health Service—has tried to grasp the nettle, but unfortunately the small section devoted to the N.H.S., Universities and Research where attention is drawn to the problem, is being overlooked because of the general apathy engendered by the report as a whole.

The Gazette adds:—

The five commissioners appointed are: Sir Frank Hartley, Chairman (formerly Vice-Chancellor of London University); Mr. Geoffrey Templeman (Vice-chancellor of Kent University and a member of the S.E. Thames R.H.A.); Dr. David Iorwerth Williams (formerly Dean of King's) and two members of the suspended A.H.A.: Sir John Prideaux (a director of the National Westminster Bank) and Miss Peggy Nuttall (formerly editor of *Nursing Times*).

Local doctors are divided over the cuts. On the one hand directors of specialist units, such as Professor Cameron and Dr. Williams (Kings' Liver Unit), vehemently oppose any cuts arguing that more patients will die if their allocation is reduced. On the other hand, Professor Peter Higgins (Dept. of General Practice) argues that the Area could be rationalised to provide better services without more patients dying. There is no denying that the cuts will affect patients, and both Mr. Jenkin and Dr. Vaughan have admitted this, but they also maintain that people will not die as a result.

It has been established that 70 per cent of a health district's expenditure is on wages and salaries. Thus if £1 million is to be saved it would be necessary (according to a study by the St. Thomas' District) to dismiss between 100 and 120 staff (at all levels in the Service). These figures must have been in the minds of the Commissioners when they decided to put a freeze on all new appointments, and more importantly, when they considered ending in-patient services to St. Olave's. However, it is not clear how the partial closure of St. Olave's will save

money. The bed numbers are apparently to be increased at Guy's and New Cross and the staff are to be "redeployed". It is not difficult to imagine St. Olave's being permanently closed and the beds being "lost" amongst the bureaucratic jungle. One only has to think of how money taken from some "rich" areas (as a result of R.A.W.P.) was never actually reallocated to the poorer areas, to imagine this to be the case.

A new type of financing is urgently required so that the Area is no longer burdened with the vast expense of the teaching hospitals. These specialist centres exist not only for the surrounding local population but also to provide services to people throughout the country (and in some cases throughout the world).

The British Medical Association has very rightly asked the Government to look into the financing of teaching hospitals. The *Gazette (Passim,* July) called for *"recognition of our* [Guy's] *national role"* and a Conservative Party study group, set up last year to investigate the matter, proposed that a separate body, to be financed by the D.H.S.S. and the A.H.A., be formed to finance the teaching centres. The editorial of *Hospital Doctor* (August 22nd, 1979) put forward a somewhat idealistic notion whereby the specialist units claim money from a patient's A.H.A. for the treatment received. This plan, though attractive in principle, would only result in a deluge of invoices requiring yet more administration.

It has been estimated that if the administration level was to be reduced to the 1973 level, the N.H.S. manpower would be cut by almost 3 per cent. It seems clear that there are too many administrative levels in the Health Service and it is to be hoped that Mr. Jenkin adopts the Royal Commission's recommendation that one tier be removed.

Beaumont - cum - Moze

Two and a half centuries of association with Guy's
by G. R. M. MOTE, L.D.S., R.C.S.(Eng.)

On a windswept corner of the salty Essex marshes at Beaumont-cum-Moze at the head of Beaumont Creek in the Walton Backwaters there is a small derelict quay which has a connection with the history of Guy's which I believe has not been previously recorded or published.

Morant, the Essex historian, writing about 1768 stated that Lord Guildford some time previously had sold the manor farms at Beaumont for the use of Mr. Thomas Guy's Hospital. This happened in 1728 six years after the founding of the hospital, when 2,482 acres of land were bought.

This farmland was close by Beaumont Quay and until the early 1960's there stood a two storied red brick building built originally probably as two residences but used for many years as a storage barn.

On the building was a plaque which read: *"This building and Quay was erected by the Governors of Guy's Hospital 1832. A. Harrison Esq Treasurer. The stones used in the Quay formed part of London Bridge built about 1170."*

Left: the storage barn at Beaumont Quay showing the plaque.

Old London Bridge was pulled down about 1824 so no doubt the Governors found a cheap source of second-hand building materials and brought the stones to Beaumont for facing the quay they were building to serve the Guy's farms.

For a century the quay was used for barges to load hay, straw and produce from the Guy's farms to transport to the London market and to unload cargoes of stable manure and coal. This trade went on until just before World War II.

In 1919, 1,532 acres of land were sold to the Essex County Council and the remaining 950 acres were disposed of in 1940.

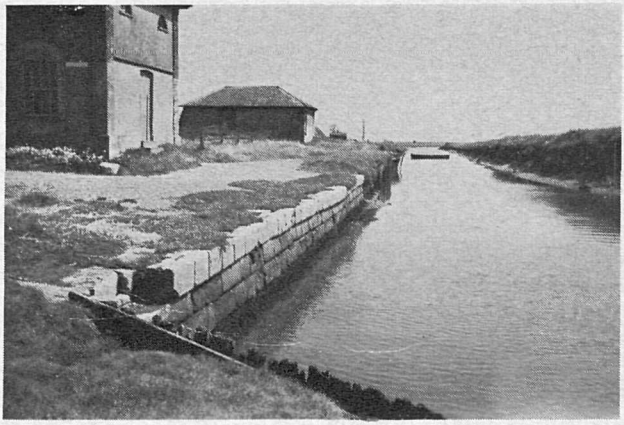
At Guy's there is of course another part of that old London Bridge. The alcove facing the Colonnade is from the same stones as the quay and was brought to the hospital in 1861 and after residing for many years in the park was moved to the East Quadrangle in 1926.

Beaumont has another connection with Guy's. A mile across the marshes is Landermere Creek. Sir William Gull, born in Colchester, lived as a boy at Landermere where he attended the village school.

His father was a barge owner and wharfinger and Gull's first connection with Guy's seems to have been brought about through his acquaintance with the then Vicar of Beaumont who was a close relative of Harrison, the Treasurer of Guy's, whose name is on the plaque at

Beaumont Quay and with whom Sir William Gull, who graduated in 1841 and appointed Physician in 1851, was to be clearly associated in later years.

This quiet corner of rural Essex served the hospital for two centuries and was the boyhood home of one of its most famous sons. At Landermere is a wall plaque to Sir William Gull. When I first went to Beaumont 20 years ago the barn and quay looked as they must have done for over a hundred years. With the masts and spars of a Thames barge on the skyline it was easy to visualise it in its heyday.



Above: Beaumont Quay

On a recent visit the much weathered and disused quay now slumbers on with beside it the barely readable plaque from the demolished barn set in some bricks from the old building and reminds the passer by that Beaumont-cum-Moze has been associated with Guy's for almost all the years since the hospital was built in 1722.

Dentine Sensitivity

by A. G. S. LUMSDEN, Senior Lecturer, Unit of Anatomy in Relation to Dentistry

and M. A. CRONSHAW, Dental Student

The sensitivity of dentine is an intriguing phenomenon. Dentine is an essential component of all vertebrate teeth, yet its sensitivity apparently serves no purpose in any living species. An explanation is by no means obvious, but from the available physiological, palaeontological

and embryological evidence a reasonable, and somewhat surprising, conclusion can be reached.

It is necessary to discuss briefly the physiological mechanism involved in the transduction of stimuli by dentine. Two basic ideas have been put forward (fig. 1). First, that the peripheral nervous system is

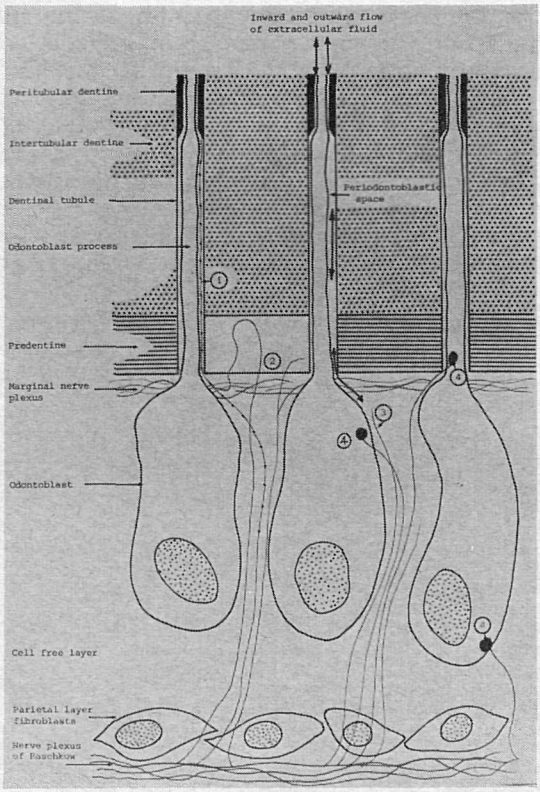


Fig. 1
1 Intradentinal nerve fibre.
2 Nerve loop in the predentine.
3 Free nerve ending in odontoblast layer.
4 Vesiculated terminal in close association with odontoblast plasma membrane.

extended into dentine and it is by direct stimulation of intradentinal nerves that a signal is generated.[1] However, only a small proportion of tubules are supplied by nerve fibres and in none of these does the fibre extend more than one-third of the distance from the pulp to the enamel-dentine junction. Furthermore, dentine reacts to a diverse range of stimuli several of which are known not to affect other peripheral nerve endings. Alternatively the odontoblast itself may act as a sensory receptor. The dentinal tubules contains extracellular fluid whose movement up or down the tubule could be detected by the odontoblast process

and passed on to nerve terminals in the region of the cell body. The diversity of agents known to elicit pain in dentine can be explained because all are capable of producing such a fluid shift. [2, 3]

Dentine first evolved in the ostracoderms, a group of primitive jawless fishes at the very beginnings of the vertebrate story, many millions of years before the appearance in the fossil record of any structure resembling a tooth. In these animals, whose closest living relatives are the lampreys and hagfish, almost the entire body was covered by a thick bony armour whose outer surface was composed of a mosaic of dentine nodules (odontodes, fig. 2). In thin section (fig. 3) this dentine is virtually indistinguishable from modern man's.[4] The complexity of dentine structure makes it hard to accept that its function in these fishes was merely that of a protective coat—a rôle for which simple avascular bone would have been a far more parsimonious alternative. It seems more likely that dentine actually evolved as a specialised exteroceptive tissue involved in relaying contacts with the environment and in monitoring changes in water temperature and salinity. The last may have been the more important in directing the evolution of this tissue. The first ostracoderms lived exclusively in sea water, they did

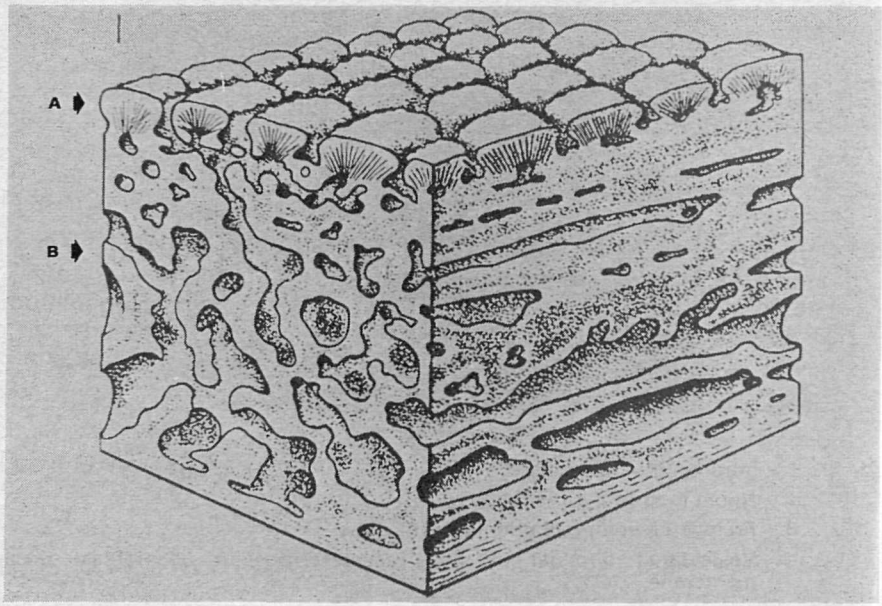


Fig. 2 A Odontodes set in a
B bone like matrix.

not possess a kidney capable of adequate osmoregulation in fresh water. Evolutionary pressures, from competition, predation etc., forced later ostracoderms to exploit increasingly less saline water. Dentine could have acted as a sensor, ensuring that a fish did not stray

beyond its osmoregulatory capacity. In water that was too fresh the stimulus felt may well have been pain, a simple aversion signal. Dentine is structurally ideal for such a function, because it is both hard and avascular but at the same time highly sensitive.

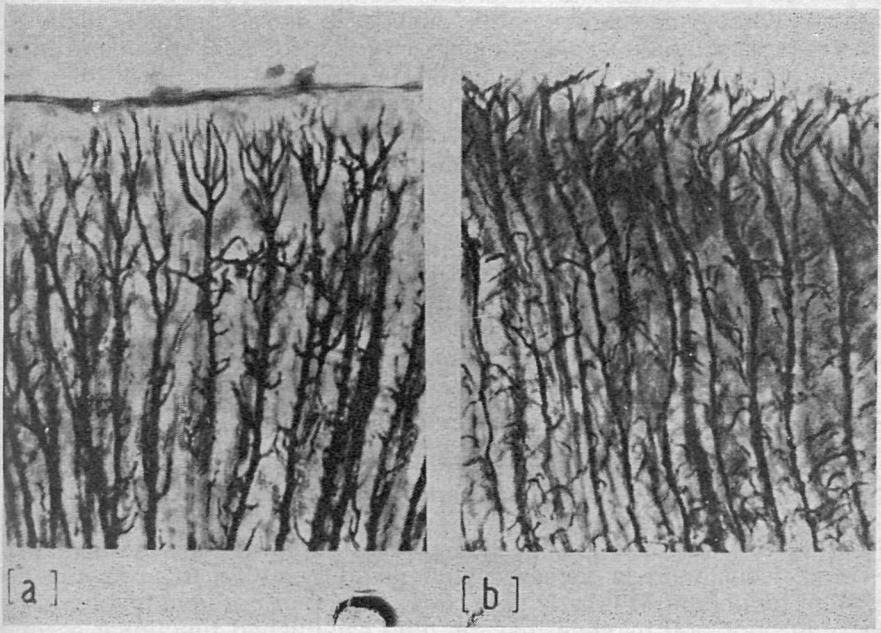


Fig. 3 Micrographs of dentine showing terminal tufts and lateral branches of dentine tubiles (a) ostracoderm dermal armour (b) human tooth x 500.
(Photos: J. R. Mercer, courtesy of L. B. Halstead)

But why do we find dentine in teeth? There are two good reasons (1) dentine is well suited to the construction of teeth, because it has a high compressive strength and is quite elastic, and (2), jaws and teeth develop, both in evolutionary and embryological terms, from the same dermal material as formed the hard, odontode containing body armour. With the appearance of vertebrate predators and the initial evolution of jaws, odontodes in the skin surrounding the mouth opening became modified to suit their new function. Selection acting on the size and shape of odontodes together with the development of a more wear resistant and desensitising enamel coating resulted in the appearance of teeth as we know them. The rôle of dentine as a sense organ became submerged as the new structural rôle became established.

The question now becomes not why is dentine sensitive, but why has it remained sensitive through 400 million years of subsequent evolution? Although it can be argued that dentinal tubules themselves

are an essential component of dentine, because they provide channels for nutrients, which ensure maintenance of the physical characteristics of the tissue, it would have been a simple step to lose the functional relationship with sensory nerves. Perhaps this has not happened mainly because no survival value would accrue to a variant animal whose dentine was insensitive: indeed, selection has acted on modifications which isolated the dentine from external stimuli. Thick enamel together with protracted peritubular and secondary dentine formation have ensured that the vital process-containing dentine is never normally exposed. This reasoning could explain the general lack of concern in the mammalian class over the retained sensitivity of one of their most important tissues; but a case still has to be made for the continued involvement of sensory nerves in the formation of teeth. In other words, although the relationship between nerves and dentine is not a disadvantage, what is its advantage?

It has long been recognised that odontoblasts differentiate from cells of the neural crest, a tissue which also provides the large majority of neuroblasts to the peripheral sensory nervous system. Recently, research has shown that the relationship between odontoblasts and neuroblasts extends beyond this identity of origin; the pioneer axons which innervate the developing jaws act as guides, directing successive immigrations of future odontoblasts from the remote region of the neural crest. Once arrived in the jaws, the sites at which these cells collect, at which teeth will later form, appear also to be directed by branches of the maxillary and mandibular nerves. The early involvement of nerves in the formation of tooth germs can be seen as an essential relationship without which teeth would not develop.[5] This developmental process had its origin at a time when the finished product, dentine, was a specialised sensory tissue and has necessarily persisted long after this previous rôle became redundant. It is only as a consequence of our own highly refined diet and poor oral hygiene that the long established functional association between odontoblast and sensory nerve has re-emerged now as a persistent source of irritation.

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Nursing

Welcome to Guy's—advice for medical students

Welcome to Guy's on behalf of the nursing staff and students! You've probably heard a lot about your studies and something about your recreation. You must have seen the nurses around the place, in their purple dresses, but maybe you don't yet know how they fit into the scheme of things.

The student nurses do not have academic terms (or holidays). They enter the hospital four times a year in sets of about fifty. After an initial six weeks in the School of Nursing, most of their training takes place on the wards, with periodic returns to the school for a week or two. A rather non-academic training you will realise. However, do not underestimate the academic ability of the nurses. Many of them have good A-levels, and some have degrees.

But if not "Just pretty faces", you may have noticed (if you are a male medical student) that some of the nurses are quite pretty. It would be nice to ask them out now and then—perhaps? Certainly most nurses would agree that it's nice to be asked, so please don't think that they are making excuses if they are working on every evening you suggest or if they ring up at the last minute to say that Sister has changed the off duty. Because not only does most of the training take place on the wards, but also the student nurses make up a large part of the nursing workforce of the hospital, which could not run without them. This means that nurses have to work B shifts—that is until 9.30 p.m.—sometimes two or three evenings a week, and they also have to do night duty for seven nights at a time, sometimes as frequently as every fourth week.

The nurses are welcomed into some of the Students' Union Clubs, and the Music Club for instance, is a combined hospital club. The same difficulties apply here—however important it is not to miss a meeting or rehearsal, sometimes it just can't be helped. Many Sisters are not very good at doing the duty rota well in advance, so planning one's off duty can be quite difficult. So please look sympathetically on these problems and don't rule the nurses out of activities because of them. You will find that they have much to contribute.

As far as work is concerned, the nurses will come into their own at the start of your clinical course. You will be a beginner at dealing with real live patients, the nurses who started at the same time as you having had a two year head start. If you want to learn from them they can teach you quite a lot. At the moment there is not much exchange between medical students and nurses on the wards. I think perhaps this is because the nurses feel that the students think themselves superior and don't want to learn from them, and the students feel that the nurses are too busy doing important things for patients to help someone who is not actually part of the team. I hope both these sets of assumptions are untrue.

This year, for the first time, the new intake of clinical medical students are going to spend some time nursing on the wards. I hope this will help to dispell some of the misunderstanding so that each group can learn from the other. After all, we are all trying to look after the same patients.

Julia Fabricius.

Physiotherapy

The report of the Royal Commission on the National Health Service was finally published in July. So deafening has been the resulting silence that one must conclude that commentators to a man were on holiday, unless the recommendations were so dramatic and far-reaching as to demand protracted analysis, or conversely that their familiar form has enabled them to melt indistinguishably into the shadowy remains of the undoubtedly wise words of all their precursors. What a depressing prospect it must be to be invited to lend one's talents to the production of a report on almost anything related to health care.

The section on the professions supplementary to medicine (or *complementary* as the report prefers) concentrates on what it sees as the linked problems of the arrangements for regulating them, and of shortages.

Regulation is in the hands of the professional bodies and of the CPSM which, as the report says, gives control of standards and qualifications to the profession themselves. This arrangement has been criticised in that while longer and more thorough training and limited entry may be consistent with the aims of the regulators, they may not be necessary to meet NHS needs. Rigidity rather than flexibility could also be induced by the registration arrangements, and the failure of the remedial gymnasts and physiotherapists to progress towards integration is cited in evidence. Earlier, reference has been made to the as yet unsuccessful efforts at amalgamation made by the 350 RG's and 15,000 physiotherapists confounding the assertion that the "differences between the training, qualification and activities of a remedial gymnast and physiotherapist are marginal", a claim that might occasion some mild dissent.

The consequence of this is that an independent review (*again*?) of the machinery set up by the PSM Act of 1960 is recommended to include the manpower and training needs of the profession.

As to shortages, the report notes that despite steady increases in the size of the professions, the potential demand of their services remains very large, rather surprisingly citing COHSE's evidence of "tremendous shortages". Widespread concern at these shortages despite the appointment of helpers is recorded and that there will continue to be an increased demand is recognised.

Like Halsbury, Merrison pinpoints the essential need to maintain an adequate supply of teachers if the numbers are to be increased, and, again, offers the opinion that integration of training between OT's, physiotherapists and RG's should take place, evidently disregarding the

discouraging results of experiments of this nature both here and abroad. It is perhaps not without significance that this opinion is not embodied in a recommendation. The need to generate more research into our work is, however.

Students of these affairs will know that this has been a continuous thread running through the reports of the last decade, and it is fair to say that responses are beginning to be detectable. Research Fellows among the remedial professionals have been designated (a Guy's teacher is one of the first two) and a post-registration research-orientated degree course is to take off in London next year. A research "special interest group" of the CSP has been formed (with another Guy's alumna in the forefront), so here at least is a recommendation which the professions would appear to have anticipated.

Ronald Cooper.

Book Reviews

"Clinical Examination", Fifth edition. Edited by John MacLeod. Pp. 476. Price £6.50 (H/B £11.00). Churchill Livingstone.

The fact that this is the fifth edition in fifteen years, with several reprintings between editions, indicates that my enthusiasm for this book is shared by many others. As an introduction to clinical skills and interpretation, in its intelligent and perceptive text, its ability to be fundamental and yet not condescending, this book scores over all its rivals as a tool for learning clinical examination. The information is well organised and presented, and the illustrations simple but first class. If I had any criticism, it would be of the first chapter, which in traditional style gives guidance on taking a medical history but offers little wisdom in the actual task that confronts the clinician, that of solving a clinical problem. Nor is the history set in the psychological and social context which has to be understood to make intelligent and effective diagnosis.

That particular criticism applies to most books of this type and "MacLeod" would still be my personal choice of "best buy" in this class of textbook.

B. HICKS,
Clinical Tutor.

"The Basis of Clinical Diagnosis", 2nd edition, by R. A. Parkins and G. D. Pegrum. Pp. 494. Price £5.95. Published by Pitman Medical

The first edition of this book appeared in 1974, and it was immediately obvious that it had several qualities, all of which have been sustained in this the second edition. A new format has made the text easier to handle and read. It should be most valuable to the clinical student who wants a guide to differential diagnosis of a range of clinical problems, organised by system and by symptom. It does not pretend to be encyclopaedic, but rather a practical aid to diagnosis at the bedside. This is not to say that it should be carried round in the pocket of the white coat, as are some other aids, but rather studied in more depth when time permits. It is clear, well illustrated and the content is generally sound, but the sections regarding physical examination or the accounts of particular medical disorders are no substitute for either the best books on clinical method or introductory textbooks of medicine. I was unhappy with some of the guides to investigation, a few of which have a slightly cursory approach or a dated feel to them. I think the clinical student who buys this book and keeps it for his house job will continue to find the diagnostic discussions useful, but he should not take it literally in for-

mulating his investigational plan. The authors express the hope that the text might be appreciated by senior nurses, physiotherapists and other non-medical health workers, and I think that their hope should be fulfilled.

B. HICKS,
Clinical Tutor.

"Statistics in Operation", by Castle. Pp. 100. Price £2.50. Published by Churchill Livingstone.

"The purpose of this book is to provide workers in the medical sciences in particular, with a cheerful, non-mathematical elementary account of the use and abuse of the statistical approach." The author begins by summarising the faults she found in a survey of the first six editions of eight medical journals in 1970; detailed statistical knowledge was not required to detect the majority. Each chapter is based on a question, which should be asked and answered when designing a research project and when reading an article, and explains the errors commonly made. The chapters discuss how to define exactly the question to be answered, how to collect the necessary information and from whom; this leads to ideas on sampling, how to choose a suitable control group and Berkson's fallacy. Data presentation includes diagrams, the Gaussian distribution, measures of central tendency and spread, standard error, confidence intervals, correlation and regression. Incidence, prevalence, crude and standardised rates as well as S.M.R.s and life tables are included. Numerous examples of incorrect conclusions drawn from simple data are given. The ideas of significance tests are introduced clearly for one example and the book finishes with a paper which has been written with a mass of errors, which the reader should be able to spot.

When explaining standard deviation the diagrams have different scales and this may catch the unwary. The reader may be confused about whether the usual assumption of approximate Normality is ever reasonable, whether to transform or use non-parametric statistics with their own disadvantages.

The writing is light-hearted but nevertheless the book abounds with practical common sense which is all too often forgotten when journals are read and research projects started. With these basic ideas readers should find it easier to read books which give more details on particular statistical techniques.

E. R. DALTON.

"Physiology of the Human Body", 5th edition, by A. C. Guyton, Pp. 520. Price £9.50. Published by Saunders.

This is the fifth edition in 20 years of a book which has now changed its name, been updated and has figures presented in two colours. The book is pitched at students in the para-medical professions and would not satisfy the medical undergraduate. The facts are well presented and most of the many diagrams make their point easily, but why include the chemical formulae of the amino acids, cholesterol and phospholipids?

The complicated story of cellular physiology is clearly written, each section in the book discusses common medical disorders and the derangement of physiology underlying them and each chapter ends with important and up-to-date references as well as some essay type questions.

The major criticism is that for the enquiring mind it is unsatisfying (e.g. the shafts of bones "exhaust their potential for growth" at adolescence; "constipation is frequently associated with headache, possibly because of absorption of toxic products from the colon". Some factual corners have been cut but this is inevitable, presumably if the book is to be kept simple and within a reasonable size—and price, which is about twice that of comparable books.

I. MACDONALD.

Guy's Hospital Gazette

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: October 15th and November 19th, 1979.

Copy may be sent to us at 16 St. Thomas Street, SE1 9RT.

Correspondence

Proposed closure of St. Olaves Hospital

Sirs,

This must come as a shock to many of the Staff at Guy's who have worked at St. Olaves during their training as Doctors or Nurses etc.

Throughout the years, St. Olaves has co-operated with Guy's and made it possible for all facilities at that hospital to be made available to our friends at Guy's.

As I understand it, the reason for suggested closure is to "save money". On that argument, then Guy's should also be closed and save even more money. Even better why not close Guy's with King's and St. Thomas', and Lewisham. The savings would be vast.

We have set up a Campaign Committee to Save St. Olaves and I have been appointed its Chairman. I ask for the co-operation and help of all those at Guy's who can help us in this fight. I understand that the final decision on proposed closure will be made on Thursday, 27th September.

If that decision is to close St. Olaves, then I do assure all those interested that we shall do everything within our power to keep this Hospital open. What methods we adopt etc., will be decided by the Campaign Committee and on that Committee are representatives of Doctors, Nurses, all sections of the Staff, the Trade Unions, Borough Councillors, and the Community Health Council.

Yours sincerely,

R. J. MELLISH, P.C. M.P.

House of Commons,
London, SW1A 0AA.

The Guy's Park

Sirs,

One of your correspondents commented recently upon the greatly improved appearance of the Park and its remarkably rapid recovery from the damage done by *Guy's Disease* (a chronic syndrome of building, demolition, and endemic botching). This recovery, which, from the nature of our Disease, is likely to be only temporary, is due to the efforts of a few individuals who are unknown to most of us, though not, presumably, to the Superintendent's Office. I am sure that many will join me in thanks to all those responsible. For my part I would like to record special appreciation to the custodian of the flower-beds, which have been particularly delightful to the eye this year. Fortunately, it is possible to record that the gardener involved is Miss Janet Stamp, who planted out the hundreds of long-flowering begonias which are still pleasing everyone who passes through the Park. In the background may be others who nurtured these beautiful plants. To them all I feel grateful, as, I am sure, do many others. We are indeed lucky to enjoy such unostentatious but highly skilled gardening experts.

Yours, etc.

ROGER WARWICK.

Department of Anatomy,
Guy's Hospital Medical School,
SE1 9RT.

Guy's "58" Reunion Dinner

Sirs,

A very successful 21st Reunion Dinner of the "58" Medical Year took place on June 23rd in the Robens Suite. More than seventy doctors with wives and husbands enjoyed this, our first reunion. The twenty-one years seemed to fade rapidly as the wine was consumed, and the evening passed all too quickly. Peter Parry, our photographer, has some good photos, and those interested in obtaining prints should contact him at 8 Bank Place, Porthmadog, Gwynedd.

Those who were unable to attend on this occasion will be pleased to hear that, by popular consent, a decision was made to hold our next reunion in 1983.

A register of the year has been compiled, and is available from me on request.

Yours faithfully,

J. F. R. ADAMS.

Pear Tree House,
26 Moorend Road,
Leckhampton,
Cheltenham, Glos.

Rugby History

August 24, 1979

Sirs,

I have just picked up my May edition of the *Gazette* from our nearest P.O. Box; 15 miles away down the mountain in North Cyprus: so by the time this letter appears (assuming that it does) the Rugby season will be well under way again, under its current President, England Trialist, and devoted historian. Tom Lewis' account is one to be treasured by every Guy's player or supporter, and I am sure we all hope he may find time to bring it up to date before (or when) he retires.

Meanwhile I should like to ask one question and add a modest postcript to the admirable series of articles just concluded. The question: how exactly *did* Teddy Morgan score his legendary try? I came to Guy's in 1933 and retired in 1974, and although I've often asked, no-one seems actually to recall just what it was he did to secure that particular niche in Rugby history.

The postscript: Tom's present account takes us up to the end of the 124th season, 1967-68. "Batch" (Mr. J. S. Batchelor, F.R.C.S.) was approaching retirement but was still indomitably running the line at most home games, and any away fixtures he could get to: supported from the stand by Marjorie his wife and me and mine.

On his retirement after the 1968-69 season I was honoured with the Presidency until I retired in my turn and Tom took over. My wife and I attended every 1st XV match, home or away, during the 4 seasons 1969-70 to 1972-73 inclusive. I kept careful records, but they alas did not survive the looting of our home during the 1974 Cyprus war. But I still have my memories and one photograph of the 1970-71 Hospital Cup winning side: Guy's 30th win in the series, beating the holders and favourites, Bart's, in the semi-finals 13–3 (and playing with an injured scrum half for most of the game), and Mary's 14–3 in the final on March 3rd, 1971. The side was captained by Fallowfield, and included among its 15 heroes Thorburn (Scottish trialist and Captain of Middlesex County XV), John Ross (Irish trialist), John Novak (England International) and Chris Neville (Kent County player).

Among other Guy's Rugby achievements during those four seasons were winning the Junior Hospitals Cup 3 times (I watched all 3), the United Hospitals Sevens, and, on the occasion of the Centenary of the Rugby Union, being invited to send a team to Twickenham for the finals of The Middlesex Sevens. There, inspired perhaps by the famous hallowed turf, capacity crowd, and the memory of the last time Guy's had played at Twickenham in 1946 when they beat the Harlequins, the Guy's Seven astonished everyone by going through to the quarter finals, trouncing London Scottish by over 30 points before going out to the Harlequins after 2 dazzlingly quick tries by Guy's in the vital opening minutes had been inexplicably disallowed by the referee.

So, despite Jonothan Earnshaw's sincere valedictory lament for Guy's Rugby (and Sarah Pearson's spirited reply), the future is still full of possibilities if enough Guy's men and women support the Club, and all those who *can* play for it, do.

With every good wish.

Yours,

DAVID STAFFORD-CLARK.

Villa Belinda,
Kautara, N Kibris
via P.O. Jskele
Mersin 10
Turkey.

Guy's Hospital Rugby Football Club

Sirs,

Thank you for your publication of details of this year's running of the Guy's Hospital R.F.C. Supporters' "200 Club". Here is a copy of the last year's draw-winners.

Prize Winners

October:

1st prize (£10), No. 003, J. Ayres.
2nd prize (whisky), No. 016, E. Dann.
3rd prize (wine), No. 068, W. Binnie.

November:

1st prize (£10), No. 002, L. Evans.
2nd prize (whisky), No. 043, E. Robinson.
3rd prize (wine), No. 050, J. Davis.

December:

1st prize (£10), No. 091, R. Laws.
2nd prize (whisky), No. 015, J. Evans.
3rd prize (wine), No. 003, J. Ayres.

January:

1st prize (£10), No. 034, J. Brazier.
2nd prize (whisky), No. 045, H. Madin.
3rd prize (wine), No. 043, E. Robinson.

February:

1st prize (£10), No. 009, S. Leonard.

2nd prize (whisky), No. 064, M. Cornelius.

3rd prize (wine), No. 085, D. Lloyd-Edwards.

March:

1st prize (£10), No. 041, S. McLachlan.
2nd prize (whisky), No. 078, A. Girling.
3rd prize (wine), No. 008, A. Sawyer.

Major Prize Draw—April 1979

1st prize (£20), No. 071, R. Flannaghan.

2nd prize (£10), No. 004, F. Morrison.

3rd prize (champagne), No. 006, G. Fowler.

4th prizes (records tokens), No. 007, G. Francis; No. 057, R. Sharp; No. 003, J. Ayres.

Thank you all for your support; I hope you have felt your contribution was worthwhile—and perhaps I can call upon your continuing subscription to the "200 Club" during the forthcoming 1979–80 Rugby season.

Further details will be published in the near future, with a subscription form in the next edition of the *Guy's Gazette.*

Dr. R. P. DUNN,

"200 Club" Secretary,
16 Glenwood Road,
Catford,
London, SE6 4NF.

Where are the Athletics and Hare and Hounds Clubs?

Sirs,

For some long time I have heard nothing of the activities of the Athletic and Hare & Hounds Clubs at Guy's or in the United Hospitals, and have seen nothing relating to these clubs in the *Guy's Gazette.*

I have received enquiries from contemporaries along these lines and this overall prompts me to write to you, and ask you to pass this letter to the appropriate secretary, or if none exists, to the Secretary of the B.M.S. Committee.

Yours sincerely,

JOHN ETHERIDGE,

73a Fitzjohn's Avenue,
NW3 6PD.

After extensive enquiries I have found the Hare and Hounds Club and a short report is found in the Sports Section. The Athletics Club has had a "rest" season this year but interest is high and I am assured that Guy's will compete (successfully) next year.

G.D.C.

More potential for B.Sc. degrees?

Sirs,

I write concerning B.Sc. degrees in the medical curriculum. Every year selected students are offered opportunities to study in several preclinical subjects. As it is the aim of the B.Sc. to include research projects, I cannot understand why students should be restricted to work in the medical school. Surely, since the opening of the Tower several students could spend part of their B.Sc. in the various laboratories, e.g. Haematology, Immunology, Microbiology, Chemical Pathology and indeed the research laboratories of the departments of Renal Medicine, Paediatrics and Genetics. In fact there are many opportunities for students to benefit from the interesting work going on at Guy's. It is my opinion that more could be done to use the full potential of the hospital facilities available and encourage those *interested* in research.

Yours faithfully,

R. CERIO,

Medical Student,
c/o Boland House,
SE1 9RT.

David Denning replies . . .

Dear Sir,

It is a pity that your anonymous reviewer of Professor Sir Keith Simpson's talk should have to resort to personal antagonism in order to defend his review. He is quite right to criticise my semi-literacy and also the view that medical education is an obstacle to literary development; a view I did not express. But would someone who was unstimulated and intimidated by a piece of writing bother to write a letter about it? I hardly think so.

One of the problems is that the reviewers have confused their objectives. On the one hand they are expecting to *communicate* effectively with their audience and on the other they aim to *educate* their readers in literary style or vocabulary or something. Perhaps they were also trying to *impress* their readers and while they certainly impressed me with their vocabulary and use of English, they failed to convey to me what was said in the talk.

The other problem is that of the language capability of their audience.

Communication is a process whereby a thought in one person's mind is transferred to another person's mind. Its effectiveness is judged by the accuracy with which that process takes place. While your reviewers used carefully chosen words to convey particular thoughts, they misjudged the capacity of their readers to comprehend those words. I looked them up in a dictionary, but how many others did?

Communication involves two parties and the effectiveness of any attempt to communicate between them is governed by the most ignorant one—not by the most knowledgeable.

If the objective of a review of this nature is to inform us, the readers, of what was said, in what manner, at a meeting, then the reviewer must be realistic about our capabilities to understand. The *Gazette's* readership is a medical one and, for the most part, we are not English scholars.

If the objective of a review is to educate us about the English language, then the *Gazette* has its editorial policy wrong in my opinion.

If the objective is to impress us, then we will be most impressed by an accurate concise account of what happened at the meeting, in terms we understand.

Perhaps my comments ought to be directed to Adrian and Philip for advocating such reviews. (They must be advocated by virtue of there being ten reviews of the same nature and allowing a response to my last letter appear as an editorial comment.) If the *Gazette* continues to be written in terms the students don't understand, it will die. It is quite simple.

Yours faithfully,

DAVID W. DENNING,

c/o Boland House,
Guy's Hospital, SE1 9RT.

Logical Positivism

Sirs,

I found the statement in John Pini's article on Logical Positivism that "*All bachelors are unmarried men*" rather amusing in a discussion on the precise use of language. It brings to mind Dr. Johnson's query, "*Is not every garden a botanical garden*?"

Consider, Sir, In the statement. "*A bachelor is an unmarried man*", the second part of the statement is simply a definition of the first. The statement "*Bachelors* are *unmarried* men" is intelligible though, since it amounts to no more than a pluralisation of a definition, whatever reasons there may be for making it are not at once obvious. The statement, "*All bachelors are unmarried men*", is, however, absurd, the word "all" being redundant. It is like saying that "All glasses (i.e. objects or vessels made of glass) are made of glass".

Yours faithfully,

ARTHUR STOCKER,

44 Golders Gardens,
London, NW11 9BU.

Centenary to Celebrate the Birth of Sir Arthur Hurst

Sirs,

Others have possibly written to you about the centenary meeting at the Royal College of Physicians. It is almost impossible to include every facet of Hurst's life in an afternoon. One omission was the introduction of his combined rounds which were held in the centre of Wilks' ward. The most dramatic and most instructive case I remember was a man who had a hysterical paraplegia which had been present for a long time. Within half an hour Hurst had the man walking and even vaulting over a small table. I was then his registrar and he said afterwards, "Now you must keep it up; get him to do it every day." Next day I tried my hardest but could not get any movement out of his legs.

The other interesting feature was the visitors who came and joined the round. Probably the most distinguished was W. B. Castle who said that without Hurst's insistence that the absence of hydrochloric acid was a factor in the causation of pernicious anaemia, he would never have done his physiological experiments, of digesting steak in his own stomach and then transferring it to the patient's and getting a "cure" of the anaemia. I thought that this had a tinge of flattery but when Castle was admitted a fellow of the Royal College of Physicians in 1964 I reminded him that he said this and asked him if it was flattery and he replied, "*Oh, no, that is true*". Another visitor who came fairly frequently was Lionel Hardy whom I

got to know very well when I came to Rugby. It was in Hardy's house that Hurst died. Another visitor was Sir Adolphe Abrahms who was a very experienced physician with whom later on I had correspondence about a patient with P.U.O. "caused" by more or less complete neutropaenia. I still do not understand why neutropaenia causes fever.

Nowadays people speak of the epidemiology of organic disease whereas in my young day it was confined to infectious diseases. In the programme at the Royal College of Physicians one of the speakers spoke of epidemiologic features of ulcers. In the discussion I said that I remember very well when I was Medical Officer to Rugby School, Hurst asked me how many boys had gastric or duodenal ulcers as he was noticing that when he took the history of patients how many said that their symptoms started at school. This I think was a new observation, which was brought home to me when I visited a military hospital in the Rhineland. Three-quarters of the ward was occupied by very young soldiers, doing their compulsory military service, who were having treatment for ulcers.

In Hurst's study of the passage of opaque material through the alimentary tract, his helpers included Geoffrey Marshall and he is the only survivor. At 92 he was not present at the R.C.P. I count myself fortunate in having been his house physician.

Perhaps I can add an anecdote about Sir John Conybeare. One evening in the Warden's House he was entertaining several of the junior staff. He was called out to a consultation. On departing he said, "Carry on and help yourselves to anything you can find". On his return some hours later he found that masses of blancmange incorporating barium had been eaten. He was surprised saying that students asked to eat it in the X-ray department said it was filthy.

Yours faithfully,

R. E. SMITH,

Area Director of Postgraduate
Medical Education,
Warwickshire Postgraduate
Medical Centre,
Stoney Stanton Road,
Coventry, CU1 4FG.

The Remarkable Joseph Towne

Sirs,

I greatly appreciated the very comprehensive article in your issue dated June 30, 1979, by Mr. J. Daws on the "Remarkable Joseph Towne". Surely this must be the most thoroughly researched account of the man and his works.

From the time I entered the dissection room at Guy's in about 1919, I was aware of the wax anatomical models made by Towne, which were present in the Museum and which afforded an accurate reproduction of the meticulous dissections made by John Hilton.

Although as students we dissected the entire body, permanent specimens for revision were not available as far as I can remember, and I used to spend much time in the Museum with the anatomy books, checking the details on models; for example, those of the vascular and nerve and muscle supply to the neck and arms, which were so beautifully reproduced. Again, the models of the thorax and abdomen and the cross sections of the trunk were most helpful, particularly when revising. I think that the models would still be of interest and value to-day, when learning topographical anatomy.

Mr. Daws mentions the volume of works which we owe to Towne. I agree that Towne must have been extraordinarily skilful and rapid in the execution of his models. In addition to the 537 wax models of Diseases of the Skin, catalogued by Hilton Fagge in 1876, and the numerous minutely detailed anatomical models, there were at one time, five hundred models of pathological specimens. These models, which were in their time the best way of visually recording a disease process, have, as far as I know, disappeared. The same fate could well have overtaken the skin models. In the second half of the nineteen thirties, I reviewed the Fagge catalogue and endeavoured to modernise the names of the diseases illustrated and to add to the text where it seemed to be appropriate. As much as possible of the original descriptions was left unaltered because of the exemplary language used. At the same time, those models which had faded and had lost their visual value were discarded by agreement. It was, however, remarkable how well the models had kept their colour and surface texture, in spite of the fact that the earliest models must have been over one hundred years old. During this time they had not been protected against light, which was particularly strong in the Museum with its glass cupola, nor against the effects of temperature; there were hot supply pipes running beneath the shelves in the section of the Museum where the specimens were kept.

I used the models for teaching clerks during their time in the Department of Dermatology and for demonstrations to the pre-clinical students in order to illustrate to them the importance of cutanous changes as markers of systematic diseases. Further, my own interest and appreciation of these models led me to visit the museum regularly so as to reinforce my own visual images of the very wide range of skin disorders illustrated. The models provided a very useful reminder of the severity of some of the skin disorders as they occurred in the previous century, and the benefits which even in 1935 were derived from social changes.

With the threat of the second world war in 1938, I was seriously concerned for the safety of these models, vulnerable as they were to bombing and fire. With the aid of my firm, we loaded half of the Museum's wax models on to a lorry and transferred them to a dry cellar in an isolated house in Wales, where they remained quite safely during the war. However, the other models had a more stormy history. The Guy's Medical School located a cave in the Surrey hills, which was clean, dry, relatively well ventilated, and which had chambers cut on each side of the access road. One of these chambers was lined with shelves and barred with an iron gateway. At least one was convinced that the models were safe from enemy action. However, some six months later, a more subtle menace was discovered. The pathway to the cave had originally been entirely dry and clean, but when I visited six months later, there was a trial of green mould, penicillium, from the entrance, and we found that one or more adjoining chambers had been let to wine merchants who had rolled their barrels through the caves and contaminated them. I should explain that the danger of mould affecting the models had indeed occurred to me. Most of the models were in their original glass cases, either in glass jars with the original covers of lead and animal skin, or in cases, the wooden frames of which were stuck together with glue. I consulted a senior member of Madame Tussaud's, who inspected the models and assured me that there was no danger of contamination by mould. He believed, incorrectly, that the models were made of paraffin wax.

By the time the damage in the cave was discovered, many of the models were coated with green mould, and some of the cases had collapsed. Fortunately, I was put in touch with the Conservation Department of the British Museum. It was pointed out to me that the material used in the models was bees' wax and that it was well able to support the growth of mould, as also was the glue of the wooden cases. Some of the models were irrevocably damaged, but others were cleaned under the direction of the British Museum by Mr. Percy Roberts (Mr. Daws' predecessor), and the work of replacing the damaged cases with Perspex was begun by Mr. Roberts and Mr. Steve Ireland.

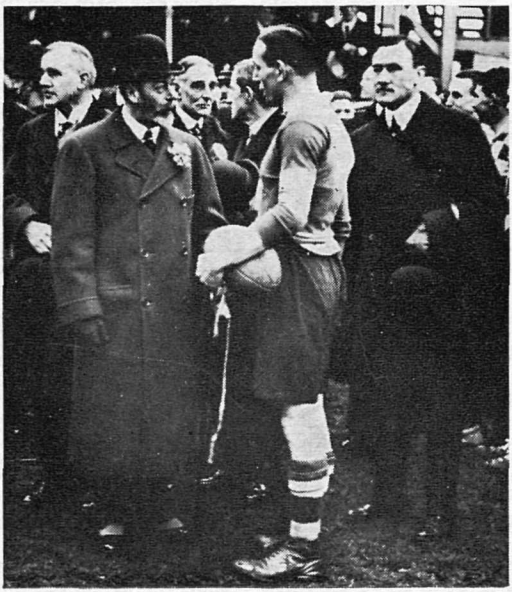
The war ended, but the saga of the models continued. I was curator of the skin section of the Museum, and was astonished, to put it mildly, to be shown articles in the local press, and also, I believe, in one of the illustrated papers, in which the then curator of the Museum stated that the wax models were of no interest and that they were to be summarily disposed of, as he needed the space for other purposes. How and where these interviews were given, remains a mystery to me. Of course, I very strenuously objected to this proposal, and, at a subsequent Medical School Council meeting was able to convince the Council that this was a monstrous suggestion.

It is now generally recognised that Towne's models are supreme examples of their art: arresting, faithful, and irreplaceable. They are safely housed in the section of the Museum which has been beautifully refurnished by the generosity of the Herbert E. Dunhill Trust and I hope that future generations of students will appreciate their educational value. For this purpose I believe that it is essential for the models to be kept on continuous display. Shelf space is sought at different times for other purposes such as displays, projecting machines, teaching machines, etc., and it is only too easy to put the models into cupboards and to leave them there. This is not likely to be allowed to happen with our present consultant staff, and I hope it will not happen in the future.

LOUIS FORMAN,

22 Harley House,
Marylebone Road,
London, NW1 5HE.

Sport



The photograph shows Guy's Captain W. D. Doherty talking to King George V before the 1921 Hospitals Cup Final in which Guy's beat the London 43—6. Those were the days! Then the best sides in the country feared Guy's and the Cup was our almost permanent possession. Since then Guy's have had many peaks and troughs in fortune and although the Cup was last won in 1971 (see Dr. Stafford-Clark's letter) I'm sure that Guy's fortunes are about to turn, (rumours of Barry John's entry to 1st MB are ill-founded). Although Guy's may never again be able to compete on equal terms with the best teams in the country, we should be able to compete successfully with other hospitals. The entry to Guy's now is more female and academically based than it has been in the past, however the situation is similar at most other hospitals and Guy's should be well able to win the Cup. Some hospitals however still seem to be biased towards rugby applicants; it is interesting that the hospital that seems to be the biggest culprit was at the centre of a controversy concerning sporting studentships way back in the 1930s.

Anyway I hope the Freshers that dare read this column have realised the heritage they have. Apart from rugby Guy's is also concerned with other matters, such as cricket, soccer and hockey, to name but a few. In recent years many of these clubs have had a degree of success on the sports field and even more so in the bar afterwards. In your first few days you will be tempted, coerced, bullied or even seduced (anyone being persuaded by this method please contact me c/o *Gazette* pigeon hole, Boland House), to join one or many clubs. This is very important, not only so the clubs concerned can survive, or be rejuvenated by the injection of fresh blood (alcohol content <80 mg. when playing if possible) but is also important from your point of view, affording a unique opportunity to see the characters/drunkards/idiots of Guy's—you might even be able to talk to them! These "sportsmen" will not only tell you that you can't play your game but if you "oil" him well enough he (or she) will be able to give advice about parties to go to, which books to buy (mine) and which lectures to miss. In an effort to entice people to

join their clubs the following pages look like holiday brochures with promises of cheap holidays (and booze) in a number of regions ranging from Germany and Italy to North Wales and Bognor. Without wishing to sound patronising, but I will anyway, I do not want our young, innocent, inexperienced, sober, upright, moral, hard working thrifty Freshers (delete where necessary) or even indeed any Past or Present Guy's men, sorry, persons who might share one of those qualities, to be shocked by the following tour reports. The reports always seem to tell of drink-ridden days alternating with eventful 20-hour journeys but true as this may be, tours are also a superb opportunity to travel, play sport and engender team spirit, as well as giving you a chance to meet new and interesting people before beating the hell out of them (on the sports field).

However a warning to all Freshers, as Andy Morgan says in his Tennis report (at least he's talking sense) it is not enough to put your name down for a particular sport and expect to be in the first team by the end of the month (or on tour at the end of the season). You have continually to make your presence known to the people who matter, a full page advert in a national paper is a good way, alternatively a small bribe (say £500) might work.

There is also another way to be noticed, be keen and go training (Richard Trembath take note). A small band of enthusiasts have been training since early Summer, mostly rugby players but joined by a motley crew including a large number of soccer players. Training can be great fun (afterwards). During training you go through every barrier known to man, the pain barrier, the oxygen barrier, vomit barrier and then more pain barrier, still it's all good fun —isn't it?

On idly examining past *Gazettes* I noticed that the Guy's Association Football Club have reports printed in the *Gazette* in 1888. Unfortunately there is a gap in our records and the next oldest *Gazette* is of 1876 where there are no soccer reports. The inquiries I've made so far have been unsuccessful in finding the exact date that the club was founded—does anyone know?

Good luck to all sportsmen for next season, remember apart from the exercise and glory, playing sport also means that you always know someone who will have a drink or bath with you.

G. D. C.

CRICKET

After such an impressive start to our cricket season, it is perhaps fitting, and to be expected, that the second half of the year should see a return to our more usual fortunes. This may be put down to several causes, although I think there are two main reasons. First, that due to our untimely (and in the case of the U.L. cup, extremely unjust) expulsions from the cup competitions, I got the impression that some players lost an amount of enthusiasm for the game. The second, and most significant, reason was the perennial problem, which all Guy's captains have to face, of picking sides from about $1\frac{1}{2}$ years-worth of students, due to exam commitments. It is my firm belief that many people take their exams far too seriously (finals excepted, of course), and that at least one afternoon off per week in the fresh air (smog) of H.O.P. will do at least as much good as harm, and probably more. (Let's hope there are at least a few suckers in our new intake who believe this, anyway.)

Which reminds me. Welcome, boys and girls (and any it who doesn't include itself amongst those), to the embracing and benevolent arms of our beloved nest, Guy's Hospital. It is with great optimism, and some desperation, that I shall try to entice some of you to represent this wonderful and very solid institution as sporting ambassadors. I say with some confidence that the cricket club is one of the most enjoyable and relaxed (we have to be) clubs in our Union, and that interest and a sense of the absurd—how else can you describe standing five hours in drizzle and rain?—are considered, by me at least, to be of equal, or greater, importance than specialist skills. We have dozens of teams, most of which go under the collective name of "1st XI", ranging from pretty damn good, to downright awful (see match reports), so if you have any interest at all, we'll fit you in somewhere. Thanks largely to the efforts of Shiraz Gulemali, we also have some 2nd XI fixtures, which we hope will be increased again this year

The other point I wish to mention to all cricketers, is that before the beginning of next season, we shall arrange again some indoor nets at the Lord's Indoor Cricket School, or at Crystal Palace. You will find this of great value, and extremely enjoyable, as they are purely for the individual cricketer's benefit, however good, and not used in any way as a selection procedure. There will be a charge made this year, but this is

nominal at most, and certainly cheaper than the equivalent hour's entertainment in many other places—including our bar. So I would be grateful if those of you who are interested could let me know, via the Cricket Club pigeon hole, when and roughly how often you would like to go, so that I know approximately how many sessions we'll need to book. I'll put up a notice about this in the near future.

It is now my grave duty to inform you of the tidings of the 1st XI since the last *Gazette*. I shall not dwell too long on them, since, out of context, they make depressing reading. The highlights, however, shall be exhibited in their deservedly glorious and exalted status.

v. Old Lambethians. H. Lost by 29 runs.

This game is marked down to experience, or stupidity, but is best not forgotten, as it contained possibly the best example of inept and inane captaincy of the season, and may be a cautionary tale for my successor. Due to excellent bowling and fielding by ourselves, allied to the fact that two opposition players didn't turn up until eight wickets had already fallen (i.e. too late to bat), O.L.'s slumped to 59 all out. My arrogance and naïvety induced me to change the order such that the lower order batsmen got their chance. Unfortunately I reckoned without their two very accurate and clever bowlers, with the result that we were bowled out for 30, including eight ducks! (Alex "Apostrophe" Williams, 0 not out.) Only Andy Mitchell, with 19 runs, remembered that the bat was supposed to actually make contact with the ball. Shame! Shame! Shame!

v. Brixton West Indians. H. Lost by 66 runs.

B.W.I.C.C. fielded a weak side, which, due again to some very tight bowling by Jacks, Thomas, myself and the inverted commas himself, plus some excellent fielding—a brilliant diving catch by the "cover point", and a Randallian run out by someone else (modesty forbids me to name him)—we were able to dismiss them for 129 runs. Unfortunately, our secret batting weapon decided to remain secret, and in spite of 20 runs by Mitchell, five by Mick Botham, sorry, Corlett, and a duck from Leaping Cougar, we were hammered out for 63. Oh dear.

v. Old Citizens. H. Lost by 73 runs.

A good side, this one, so I think a word is needed with the fixture secretary. However, we didn't do too badly (perhaps explicable since I wasn't playing), considering we fielded what was only just a 2nd team. Some reasonable bowling, especially by our M.C.C. batsman, Rick Plowman, restricted O.C.'s (who can include an Oxbridge blue and an Indian Test player among their members—though thankfully not playing on this occasion) to 191 for 6 dec. Unfortunately only Simon Gregson (15), Rick Plowman (56), and Chris Thomas (22) had any answer to their attack, and 118 was the best we could manage.

v. Old Castletonians. H. Lost by (oh, God) 142 runs.

We were again up against a side which, had we been able to field even a moderately strong side, let alone our best, we would probably have thrashed. However, we couldn't, and the reverse applied. Some very poor bowling (myself as guilty as any), "backed up" with some hilariously bad fielding gave their competent, but by no means exceptional, batting side 237 for 6 dec. Their bowling was at best fair, but only Simon Cunnington (26), playing his first game for years (almost), Simon Perkins, and Francis Hughes could do anything at all. Result: 95 all out.

I'd just like to finish off with a review of the season and averages, and a couple of general points.

OVERALL

Won 7, Drawn 3, Lost 7

BATTING AVERAGES

(Over 10, with more than 6 innings)

	In's	N.O.	Highest Score	Runs	Av.
Mike Glover	8	1	146	402	57.3
Alasdair Jacks	10	4	105 n.o.	305	50.8
Charlie Tunnadine .	15	3	92	490	40.8
John North	8	2	39	146	27.3
Andy Mitchell ...	10	1	49 n.o.	202	22.4
Peter Jolliffe	9	0	32	161	17.9
Alex Williams ...	11	1	58	135	13.5
Mark Powlson ...	2	0	0	0	.0

BOWLING AVERAGES

(more than 20 overs)

	Overs	Runs	W'kts	Av.
Alex Williams	159	458	37	12.2
Charlie Tunnadine ...	112.2	345	26	13.3
Alasdair Jacks	86.3	325	24	13.7
Mike Glover	61.3	246	13	19.0
Andy Mitchell	23.4	78	4	19.5
Paul Shepherd	65	189	3	63.0

I should like to apologise for our lack of success in either the U.H. cup or the U.L. cup. These were discussed in the last issue. The former? Well, these things happen. I think it disgraceful that we should pay £25 entrance fee to the U.H., which is supposed to cover the provision of umpires, and then to have no umpires provided. Many decisions were made which caused some ill-feeling between the sides, which would have been avoided, had the U.H. done its duty. Strong representations will be made about this. As for the U.L. cup fiasco, the same applies, and we will attend the next U.L. A.G.M. in force, to see this does not happen again.

The cricket club A.G.M. will be held sometime in the near future (or past), to elect officers for the club for next year, and to discuss any suggestions anyone may have. I hope some of you will find time to attend. A notice will be displayed informing you of the date and time.

I look forward to seeing you kiddiwinkies at the Freshers' Fair, where I hope I can be of use to you. We need all the talent we can get. Hopefully, if we get a reasonable pitch ready by next year (of which I'm sure H.O.P. is capable of sustaining, in spite of the evidence of recent years) we may enjoy even greater success under next year's captain—whoever he may be. I wish him luck, and as much pleasure as I've gained from the experience.

Charles Tunnadine.

[Editor's note: The man with a truss-like function (supportive role) in the batting averages played three innings at least.]

SOCCER CLUB

This season Guy's again fields three teams in the University of London League, each team also playing in two cup competitions. Competition to play in the teams has always been great, not only because of the opportunity to play soccer but also because of the social aspects of the teams.

Interest in the club has also been revived following the successful tour of Germany at Easter where teams such as R.A.F. Germany and the B.A.O.R. were given tough games (at least in the first half, before the rigours of being on tour came into effect). Interest in the club is also shown by the large numbers of soccer players attending pre-season training (two months before the first league match!). However anybody who wants to play soccer is very welcome as long as they've got at least one leg to kick the ball with and a strong instinct (plus a good right arm to reach down into pockets and up to the mouth!).

The captain of the 1st XI is Dave "Nijinsky" (after the dancer, not horse) Smalley, of the 2nd XI Gary "Gentle Giant" Calver and of the 3rd XI Mick (who?) Corlett, all dynamic captains ready to stir their respective teams on to success. Watch the notice boards for announcements.

See you at the trials.

GUY'S RUGBY CLUB 1979–80

As you may know Guy's is the oldest rugby club in the world—in its 136th season. It has a long and glorious history, especially in the Hospitals' Cup which we have won more times than any other hospital.

The Club now intends to run four or more sides on Saturday afternoon with a Wednesday XV and a "Preclinical" XV and earnestly needs the support of freshers as players to maintain standards and keep the Club running smoothly.

The officials for the coming year are:

Mr. T. L. T. Lewis, President.
B. Keevil, Captain.
G. Manning, Vice-Captain.
Dr. S. Challacombe, Treasurer.
G. Parry, Hon. Secretary.
A. Girling, Fixture Secretary.
T. Palmer, Social Secretary.
H. Williams, Team Secretary.

These people will become more familiar to you as you join in the social life, especially if you visit the bar regularly enough!

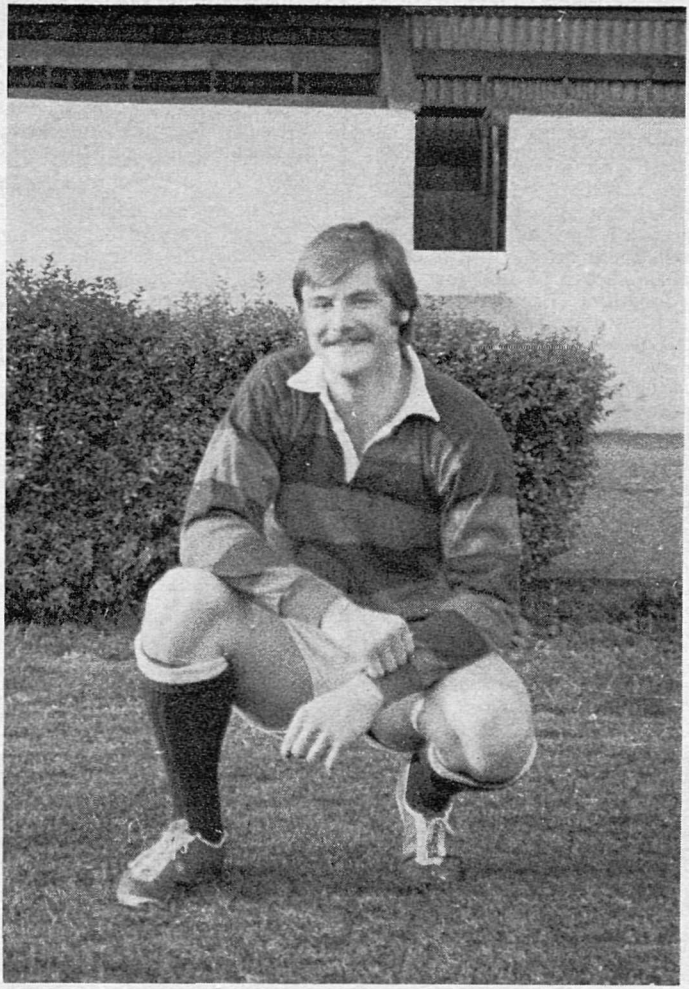
Training will be on Tuesday (5.30 p.m. Pavy Gym—Guy's) and Thursday (5.30 p.m. Honor Oak Park).

The Freshers Trial is at H.O.P., 3rd October at 2 p.m. and make yourselves known to the Club at the Freshers tea party on 1st October.

Best of luck to all new players in the Club—those from Oxford and Cambridge as well—remember the season culminates in a tour to Germany where beer is said to be *very* cheap in the forces bar. Roll on Easter.

Home fixtures for October/November:

Oct. 21 Old Dunstonians, 3.00.
Nov. 3 Ipswich, 2.45.
17 Old Merch. Taylors, 2.45.
24 Mountain Ash, 2.45.



Rugby Captain Brian Keevil looking like Brian Keevil. (Special pin-up versions available from R. Dunn, c/o Playgirl.)

TENNIS

Men's

Believe it or not the tennis season is not yet over. Having won the Hospitals League, we are still trying to complete the Cup competition. One win and a couple of disappointing walk-overs have put us in the Final, which we will endeavour to win. It is sad that at a time when Guy's has such a good team many of the other hospital teams are languishing in a state of disorganised apathy.

I have been rightly ticked off for making some snide comments in this column about some of the players who have represented Guy's in the friendly matches this season. There is no need to sue; I withdraw them all. They were just

a means of enlivening these terribly boring tennis reports that Gary forces me to write at monthly intervals. I would like to make it clear, here and now, how grateful I am to everyone who played in any of the teams. Even the sports editor, in his outrageously garish socks, was an asset to our team on one memorable occasion.

While poking fun at some of the less serious players, I have often neglected to mention in these articles the nucleus of the 1st team. Let it be said that Tim Thurston, Jonathan Pringle, Richard Wellington, Rick Plowman and Simon Moore (but only when he's wearing his 1940's pair of woollen shorts) have all played incredibly well and made the Guy's team the best of all the hospitals this season.

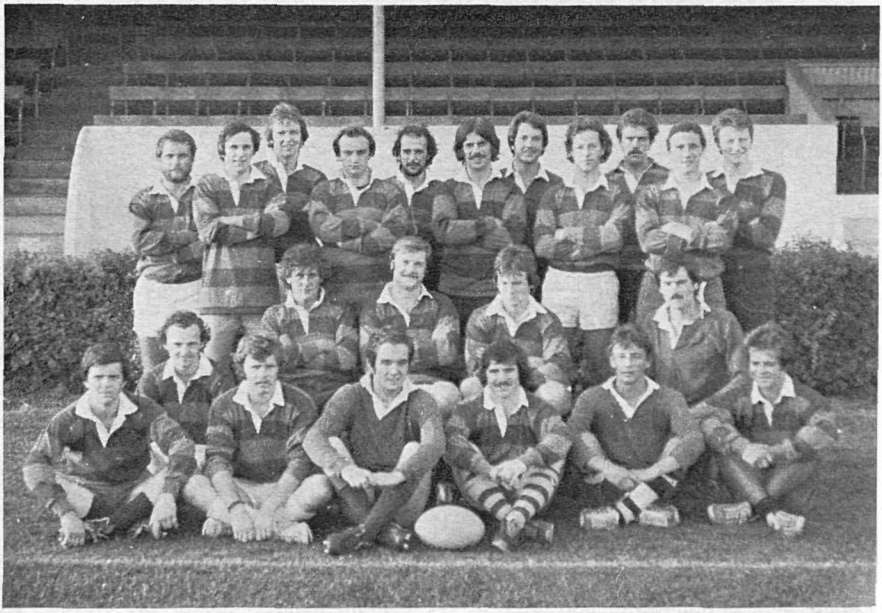
As for next year, the prospects are good but it is essential that newcomers to Guy's show willingness to play for the teams. Apart from arranging trials, which are inevitably rained off, it is always difficult to find out who the new players are. It is largely up to them to contact any of the present team and show the necessary interest, rather than to simply sign the piece of paper at the Freshers' Fair and automatically expect to start playing for Guy's next Summer.

Andy Morgan.

Ladies

The early summer dawned. Eager-eyed the telephone numbers of counterparts at the more chaotic hospitals were obtained. The numbers were dialled. "She's out"/"gone to a party"/"in Nepal for the weekend." Undeterred, a fixture list was prepared. Success without a league.

"Who would like to play for the team?" Far too many it seemed, we could have had five teams rather than one. Was it the prospect of mixed



Rugby: "The Guy's Squad"—on whom all our hopes rest.

matches? These were a great success. Maybe it was the prospect of our names in neon lights winning the Hospitals Cup—and we did make it to the semi-final. We won nearly all of our twelve matches, our reputation had become so fearful that upon arrival at the "London" for our last match they did not even dare to turn up.

The highlight of the season was as usual Sports day. The weather had brightened up after fears of the event being washed out. Thirty-two couples arrived with their armour-plated rackets and persil white uniforms. But in the battle of the day it was the fairer sex who *undoubtedly* won. The men swallowed their *bitter* (sweet pill of defeat).

Our thanks to all players especially: Angela Mackenzie, Pippa Herald, Caroline Fraser, Clare Watts, Jill Martin, Clare Keyte, Elaine Dare, Debbie Uwins, Nicky Coppock.

All lady tennis players are welcome.

Anne and Julia Kerslake, Captain and Secretary.

LADIES' SWIMMING CLUB

Dear Freshers—Welcome to Guy's. We are very fortunate at Guy's to have a very good swimming pool on our doorstep and we hope that you will all discover it soon and make good use of it. For those who are keen on swimming the students' swimming club has use of the pool between 6–7.30 p.m. on Mondays and Wednesdays. The Ladies' and Men's teams train together on these nights.

As well as swimming we also play water polo. The ladies have only had a team for one year, but so far we have won all our matches. Water polo can be played by swimmers of all standards and can be great fun.

Most of our swimming and water polo matches are against other London colleges. Every year we also enter the University Swimming Competition and the United Hospitals Swimming Cup in which we usually do well.

If you are interested in joining the swimming club come along on Monday or Wednesday evening after 6 p.m.—or contact me via pigeon holes in Boland House.

Mary Ganczakowski (Captain).

WATER POLO

Last year the water polo team had its best season since 1969/70 when it won all four of the annual competitions (the University of London union league and knockout and the United Hospitals' league and knockout).

The 1st team came third out of seven in the first division of the U.H. league, always being narrowly defeated by the two dominating teams, Bart's and The London. Unfortunately in the spring the team met with the same opposition and once again finished third in the first division of the U.L.U. league.

However it was in the knockout competitions that form was really found. Guy's won the U.L.U. Cup, making their way to the final where they beat Bart's. This success was almost equalled in May in the U.H. Cup when a depleted Guy's team lost to a very strong Bart's team 5 : 4 in the final.

The second team also managed to come third out of seven in the second division of the U.H. league.

Consequently it was with some confidence that we embarked on the (now traditional) tour of the West Country in July. We were overjoyed to hear we were to be joined by John Taylor and his (now traditional) gesture.

Previously the first match v. Yeovil on the Friday night has found the team unfit but this year we came out on top winning 5 : 3 with Ray Vella scoring four of the goals. The rest of the evening was spent "celebrating in the usual manner" and in revisiting a delightful Chinese takeaway.

The Saturday lunchtime match was against Bridport in the river at West Bay. There the murkiness of the water hides a multitude of sins and its temperature caused a multitude of reascensions. Still, despite these three problems, we again managed to win, 5 : 3, and after some massaging and counting we "celebrated in the usual manner".

That evening we were due to play in Tislaing and after the earlier match we were disappointed to find we would again be playing outdoors (nobody more so than Mike Evans who had joined the tour late to avoid the trauma of playing at Bridport). In the water the temperature was no problem. There just wasn't must water in the shallow end—it was only 2ft. 6in. deep! This provided some difficulty for the goalie, John Beard who immediately started looking for a cricket box. (We conceded one goal because he couldn't reach far enough down for the ball.) However we were again victorious against a fairly inexperienced side, beating them 7 : 4.

Once more we retired to "celebrate in the usual manner" and Andy White, unable to find the little girl he made eyes at last year, passed the time in a rather strange way.

The climax of the tour is always the match against Bournemouth, where often only one goal separates the teams. In an exciting and terse game Gabriel Tee and Ray Vella scored goals against very tight marking to give us a 3 : 2 victory.

The team won four matches from four, scoring 20 goals and conceding 12; most successful goal scorers were Ray Vella getting six and Mark Vella and Gabriel Tee each scoring five.

The squad was: D. Rickard (Capt.), Gabriel Tee, John Beard, Ray Vella, Mark Vella, Mike Miller, John Taylor, Greg Wilcox, Andy White, Mike Evans and Pete Robinson.

After such an enjoyable season it is a shame that the club will be losing so many of its salwart supporters: Mike Miller, John Beard, Mark Vella, Gabriel Tee and soon Dave Rickard. All these players have been of invaluable service in the last few years and this opportunity should be taken to thank them on behalf of the club.

Because of this new players will be desperately needed. Anybody interested in joining the club should contact us via the pigeon holes in the East Wing or come along to a "training" session in the Orchard-Lisle pool on Monday nights at 6 p.m.

P. G. R.

HARE AND HOUNDS CLUB

In the past two weeks there has been such an unprecedented interest shown in the Club that we have been coerced into advertising ourselves in print once again.

This year as is usual five or six Guy's Hares will be disporting themselves in the University of London League as well as any inter-Hospital fixtures which are held. The size of the teams for these events is usually four but any number can race, the best finishers make up the team. If there are any Freshers or anyone else for that matter who fancies a run please contact either me or our elusive secretary Kevin McKinley via the Boland House notice boards.

Chas Newstead, Captain.

LADIES' HOCKEY CLUB

Welcome to all freshers on behalf of the Ladies' Hockey Club. We look forward to your support either on the field or from the side lines.

Last season we fielded one side only, and entered the U.L.U. cup and University Colleges league. Most league games were either won or drawn—only a very few being lost—putting us high in the final league table. In the cup we won our division and a win over St. Mary's in the semi-final led us to a fiercely contested final against Chelsea College which we neither won nor drew 3—2. However it is our intention to bring the cup home next season.

The following awards were made: Full Blue to Julie; and half Blues to *Kristin/Christin, Debbie and Cathy.

At the A.G.M. at the end of the season the following were elected for the coming season: Hon. Secretary, Helen Reece; Captain, Sally Clark; Vice-Captain, Sian Thomas. It was decided at this meeting that regular training sessions should be introduced, that two sides should be fielded and that a tour should be arranged.

Training sessions, which have already commenced are held on Monday nights at H.O.P. in conjunction with the physiotherapists' team and casual males in need of exercise.

A first team has been entered in the league and the cup and regular friendly fixtures are being arranged for a Second team. Depending on the support for and the success of the second team, we hope to enter two teams in both the cup and the league next season. Some suggestion has also been made that the ladies join the men on tour to Italy next year.

Our thanks to the men for their invitation to join them for a combined annual dinner after the A.G.M. This was a great success and led to the unanimous male decision that there be still greater affiliation between members of the two clubs in the future!

Finally our thanks to *Kristin/Christin for all her hard work and enthusiasm during last season, to Joyce and Eric Dann for making our home matches so enjoyable, to Ken our tolerant and reliable umpire, and to both our supporters who are two numerous to mention by name.

S. M. C.

The Cup Final side that lost to Chelsea 3—2 last Spring.

HOCKEY

THURSDAY

1st XI Italian Tour 1979

The team collected at the East Wing before leaving for Victoria. Due to a last minute cancellation it was deemed suitable that the replacement should be the Honourable Bar Secretary who brought his own kit, item: one jug. At Victoria we noticed that one member of the team had already traded his kit in for two crates of Long Life. The team was, therefore, in full tour spirit by Brixton. The train(ing) continued to Dover where we boarded the ferry. At Boulogne we boarded the train which was to become our home for rather longer than we expected. The French countryside was greatly admired until Paris where beverage refreshments were obtained en masse and although we feel sure the quality of the countryside remained, our admiration became somewhat blurred! Various people stirred at Dijon station and night caps consisting of a small tot of whisky were finished about 11.00 and some of the team retired.

FRIDAY

As we approached the Alps team Manuelle (Forber) explained that as the Italian Government knew we were coming the national railway system was on strike, we therefore had to make an eight-hour detour round the Alps. The train then terminated at Milano—the driver's home! The Torino train was now caught, however the driver lived en route—and parked it outside his house! The Guy's boys took on the appearance of a St. Trinian's team and a coach promptly arrived—things were looking up, but this one stopped halfway and we needed another coach. Upon arriving at Torino—just 9½ hours late—it was found that our marvellous organiser had arranged for us to be met at this time. Brilliantly planned! Not even a strike could stop us now.

Our friends from Villar Perosa knew our priorities and within five minutes

we were at a wayside bistro having rolls —and beer. After arriving at our hotel and dining Guy's boys put all their energies into impressing upon the Italians that they were serious contestants.

SATURDAY

The morning match against Genoa, possibly the worst side in the competition was unfortunately lost 1—0— obviously the long journey had taken its toll. But with ample refreshment at lunch and full Guy's tradition a 100 per cent improvement was found for Guy's to beat the Swiss side Blau-Weiss 1—0. The goal, a classic move was scored early in the second half by Chris Darby after some good interplay with Jones. By now the volatile Italian crowd was on our side—this was to prove useful later.

On Saturday night a party was held at our hotel for all the teams partaking. The food was superb in both quality and quantity and the wine was effective. The Italian hospitality was excellent and a most enjoyable evening was had by all with Guy's proving that they can out toast anyone. Forber again got the tie after an incident with a pretty girl's head and a plate of ravioli. This was termed an accidenti by the team linguist whose arm waving and pigeon French looked and sounded very stupid. Later on we met the only member left of the German opposition for the next day. He had been dispatched to make sure we all slept well. We seemed to manage without his help.

SUNDAY

Sunday dawned very hot, as usual, and Guy's took the field against a strong German side from Ulm. Against this strong opposition we began to remember how to play and although we lost 2—0 we played a hard game and had several chances. The game will be remembered by Garth Saward—normally such a placid person, who after ruthlessly chopping down the opposition left-winger was heard to say "Qai" to the umpire as he received his card. During the game good performances were given by Plowman, Karim and Wyeth.

In the lunch interlude we learnt we were runners-up in our group; this meant we had to play Moncaloo an Italian side for third place. With a crowd of about 300 mostly on our side we started well with most of us playing in strange positions. Cunnington showed us he had lost little of his old magic after his accidenti. Half-time was reached scoreless and normal positions were resumed for the second half. A goal was given away just after half-time (as usual) and several shots went close. The umpires were too fast on the whistle and even when Pascoe managed to make contact he was blown up. Guy's fought back with great spirit and after having two shots cleared off the line we equalised with a goal from Hugh Jones after a cross from Plowman. By now with the strong sun and the morning match we were almost spent, but with crowd and side-line encouragement we found our last reserves of energy. With two minutes to go we were awarded a free hit on the opposition "25" and Forber struck a fine pass for Wyeth to slot home the winner. (He won't score many better.) The crowd erupted and Guy's, the first English side to be invited had managed a creditable third place (out of eight). We even made the Italian national daily papers although for what we're not sure! The tournament was won by the hosts Villar Perosa with the Germans second.

Unfortunately all good things must come to an end and after receiving our cup and plaque (and the largest cheer) half the team had to leave. The rest stayed to celebrate with the Perosa boys and "Just one more vino". Darby and Captain "Pip Pip Hic" Forber became casualties. So concluded one of the best and most enjoyable ventures the Hockey Club have yet undertaken. The tour was a great success as we made many friends and we will doubtless be invited next year—this must augur well for the future of the club. We also received two more tour invitations, one to Mafia country—but we are not sure of the undertones here!

It only remains to thank the team putting in the effort on the pitch and sacrificing valuable revision and "points" time to make the trip. Also to Rob Forber as without his Italian we would still be stuck on a train in central Italy saying "Qai". Our condolences to Dave Hett who was unable to make the trip: quote, "He would have been in his element".

Team: Pascoe, Saward, Harris, Singh, Sanders, Jones (Hugh), Forber, Darby, Jones (Duncan), Plowman, Wyeth, Karim.

P.S. FRESHERS: If any of you wish to play hockey for Guy's and help keep up these excellent tours and friendly contacts we have made please don't hesitate to contact Dave Hett or Duncan Jones or any hockey player.

D. Jones and P. Sanders.

Hockey Club on tour—Captain Duncan trying to sell a Guy's sweatshirt to the German side Ulm.

Captain Jones with the Cup (for coming 3rd or drinking most?)

GUY'S HOSPITAL RUGBY FOOTBALL CLUB

FOUNDED 1843

President: T. L. T. Lewis, F.R.C.O.G., F.R.C.S.
Ground: Brockley Rise, Honor Oak Park, S.E.23
Telephone: 690 1612
Nearest Stations: Honor Oak Park, Crofton Park (Southern Region)

Guys Hospital,
London Bridge, S.E.1
Telephone: 407 7600

GUY'S HOSPITAL R.F.C. SUPPORTERS – 200 CLUB

Following its innovation last year, it is hoped to continue the "200 Club" as a fund raiser for the Guy's Hospital R.F.C. again throughout this the 1979-80 season, but for this we are reliant on your support.

The target is to enrol 200 members, each contributing £1.00 per month for seven months. Of the total revenue half is paid in prizes—drawn each month at 1st XV home games, with the final draw being made at the Annual Ball.

Last year we had over half our quota subscribing, and in the correspondence section is a list of last year's prize winners. The larger the membership of the "200 Club", the greater the number of prizes that will be paid and the greater will be the benefit of the Rugby Club.

Results will be published monthly in the *Guy's Gazette*, the first draw taking place in late November at H.O.P.

Please complete the form below, and return it with a cheque for 7 x £1.00, or the completed banker's order form for monthly payments to the secretary at the address below:

Chairman: Dr. S. J. Challacombe Treasurer: Mr. G. R. W. Manning

Secretary: Dr. R. P. Dunn, "200 Club",
16 Glenwood Road, Catford, London, SE6 4NF.

Please allow 21 days for reply, and return of your "200 Club" Number. I agree to pledge £1.00 per month for seven months to the "200 Club". I understand that this is a binding agreement, non-transferable, and I am over 18 years of age.

Signed..... Date.....

Name (Block Capitals) ..... Payment (please tick)

Address ..... Monthly (Bankers

..... Order) .....

..... One Payment £7.00 .....

..... Cheque ..... P.O. .....

BANKER'S ORDER FORM FOR SUBSCRIPTION

To Messrs. ..... (Bankers) .....

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Date .....

MOUNTAINEERING CLUB

Guy's M.C. provides opportunities for exciting weekends. We hold three trips each term, some to Snowdonia, others to the Lake District and Derbyshire. Often we camp but in mid-winter retire to the comforts of the luxurious (?) huts. The club has tents and climbing gear which you may borrow on club trips, or at other times, and if you don't know how to use it someone will always show you!

Some members spend their weekends clinging (we hope) to rock faces, others prefer to tramp across the hills—whatever the weather! But however each spends his day one thing is sure—he'll be in the pub after a hearty meal, telling his friends about the endless epics and narrow escapes of the day!

The club also holds occasional film shows, and slide evenings when members seem to try to find the most compromising shots of each other.

Everyone is welcome on trips, or at slide evenings—all you need is a pair of boots and plenty of energy!

Jean Prior (Secretary).

GOLF

Open Competition

An Open competition will be held on Wednesday, 31st October, 1979. It will be open to students, ex-Guy's pre-registration house officers and all doctors and dentists at Guy's. Entry fees are: Student member of Sundridge Park golf club £5.00, student non-member £7.00, others £11.00. Entries limited to 40 competitors.

Anybody interested should write to:
Mike Craigen,
Golf Club,
Boland House,
Guy's Hospital, SE1.

An entry form will be sent by return of post. The closing date will be October 17th and it will be assumed that a request for an entry form before that date is an indication of entry.

Mike Craigen.

Hospital Information

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PERSONAL

ENGAGEMENT

THE engagement is announced between Mr. Roger D. Davies, B.Sc. (Medical Student), to Miss Sally M. Bird, S.R.N.

Guy's Hospital Gazette

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MANAGER — PAT POULTER

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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Guy's Hospital Gazette

The Gazette has now moved to offices in the basement of Mary Sheridan House, opposite our old premises in St. Thomas' Street. We are in the building between the Morland Adams shops and old St. Thomas' Chapter House. Office hours are 9 o'clock to 3 o'clock, Mondays, Tuesdays and Thursdays. You will see us signposted! Our telephone number remains unchanged.

THE ADVERTS WE DESERVE?

Take a look at this advert. It comes from the *Archivos Dominicados de Pediatrica,* a noted third world medical journal (Arch. Dom Ped. Vol. 14. 1978 No. 3). We venture to suggest that soft drinks would not receive promotion in a British paediatric journal, but perhaps they are not so short of money. The different approach at present adopted by western companies toward their third world clients really needs no reiteration in these columns. We note that artificial milks continue to make up a significant proportion of the advertising in the quoted journal despite recent international concern about their misuse in third world countries. But what of our own position?

Drug advertising would appear to be a rather specialised business. Everyone knows that the best way of selling shoe polish is to photograph

a girl balancing a tin or two on some part of her anatomy, and there are many other advertising favourites; fast cars, helicopters, smiling milkmen (do they exist?), happy families (another rarity) . . . in fact the list is endless!

But aren't drugs different?

Drug advertising is not orientated to laymen (the sort who like seeing pretty girls and fast cars) but to doctors (professional sorts who presumably couldn't care less about girls and fast cars). The images are different but the same hard sell techniques apply.

Some companies have even given up relating their product to the matter of the glossy, eye-catching advertisements. Ciba Geigy used to print photographs of racing yachts, for example, adding the product name almost as an afterthought.

Presumably such advertising is not in vain. The expense is enormous so there must be a suitable recompense. By reacting to drug promotions, doctors must accept some share of the blame for the deluge of advertising that is thrust through their letter boxes each day. Furthermore we shouldn't forget that the money generated by drug advertisements is responsible for the existence of many journals (eg. *Medicine),* which *might otherwise be uneconomical to print.*

Present day students won't remember the advertisement for *Distival* (thalidomide) which pictured an infant reaching up to a medicine cupboard with the caption *"This child's life may depend on the safety of Distival".* With hindsight this is tragic but at the time (December 1960) it seemed perfectly justifiable.

There is no doubt that drug companies have a very important responsibility to ensure that the data they present with an advertisement is accurate and not misleading. This responsibility goes beyond ensuring that any woman featured in an oral contraceptive ad is wearing the appropriate rings on her left ring finger. In our view the techniques of the advertising agencies are inappropriate to the serious matter of selecting the right drug for the right patient. On the other hand if the advertisements are simply there to add a splash of colour, then let's have the girls back!

News in Brief

Nobel Prize for EMI Scanner man

Our warmest congratulations to Dr. Godfrey N. Hounsfield, F.R.S., the inventor of the EMI Scanner, on his recent Nobel Prize for Medicine and Physiology. In July last year we published a special Scanner Issue to bring practitioners up to date on this British invention; a few back numbers are still available priced 30 pence from the *Gazette* Office.

Miss Jean Jones

We are pleased to report that Miss Jones, Assistant Principal of the School of Physiotherapy, has been appointed Deputy Chief Examiner for Part I of the Chartered Society of Physiotherapy Examinations for 1980–81.

Mrs. S. S. Kitchen, M.Sc., M.C.S.P., Dip.T.P.

Sheila Kitchen has returned to the School of Physiotherapy after a years leave of absence during which she has gained an M.Sc. in Biomechanics with Distinction from the University of Surrey. Her thesis was on Correlation of Clinical Gait Patterns.

Mr. Guy Blackburn

Our heartiest congratulations to Mr. Guy Blackburn, Consultant Emeritus at this Hospital, who has been elected Senior Warden of the Worshipful Society of Apothecaries of London.

Finnish Students visit Guy's

Thirty final year Medical students from Oulun Yliopiso, Finland visited Guy's on Friday, 12th October as guests of the Student Medical Education Committee and the Clubs' Union. The visitors were equally fascinated by the Gordon Museum, Guy's Tower, the Chapel crypt and the bar, but seemed to feel most at home in *"The George"*. They could hardly believe the old fashioned wards in New Guy's House—fortunately prehistoric Hunts House was not on the tour. The Guy's organisers felt that the visit had been both enjoyable and rewarding for both groups.

S.M.E.C. Elections

The Student Medical Education Committee elections are being held this Monday (28th October) for contested posts. Nominations closed on the 23rd. Medical students in all the years are urged to support their candidates at the poll.

Rugby Club Bonfire and Disco

On Wednesday, November 7th the Rugby Club will be holding their bonfire and disco at Honor Oak Park. The gates will be open from 7.30 p.m. onwards and programmes are £1.00 in advance, £1.50 at the gate. The firework display is at 8.30 p.m.

Sponsored Bed Push

Seven Post Office workers recently staged a sponsored bed-push from their London Bridge offices to the Elephant and Castle and back. The push, which was to raise money for a kidney machine at Guy's, went well except for a 20 minute delay when the bed was stranded amidst the juggernauts on the Elephant and Castle roundabout.

B.B.C. in Guy's

It would seem that the B.B.C. are concerned about the health of those whom it sets about to interrogate. The *"Michael Parkinson Show"* is now recorded at the Greenwood Theatre at Guy's, as is the even more traumatic *"Question Time"* conducted by Robin Day. Future victims for the bright light and interrogation include the Right Hon. Michael Foot MP, Edna O'Brien, and the Most Rev. Derek Worlock.

National Westminster Bank

The *Gazette* wishes to apologise to Mr. Stockwell, recently appointed as Assistant Manager to the Southwark Branch, for our unfortunate misprint of his name in the Freshers' Edition. Our thanks also to all concerned for their kind hospitality on Tuesday 2nd, at the Cheese and Wine Party.

Dates from the Dental Diary

November

Mon. 5 Prize Examination in General Subjects begins.

Fri. 9 Applications for the Final L.D.S. Examination, Parts I and III (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Mon. 19 Third B.D.S. Examination, Parts I, II, III, IV and V begins.

Mon. 26 N.B. Second B.D.S. Examination may begin this week.

Dates from the Medical Diary

November

Fri. 14 Examinations for the M.B., B.S. (Revised Regulations) begin this week.

Mon. 17 Entries close for Final Conjoint Examination in December.

Mon. 24 Examination for M.B., B.Chir. (Cambridge) may begin.

The Cover

The Cover this month shows the Gordon Museum in Guy's Hospital Medical School.

Appreciation

Mr. L. F. W. Salmon

Leslie Frederic William Salmon came to Guy's in October 1933 and qualified in 1938 having been awarded the Charles Oldham prize in Ophthalmology the previous year. He was House Surgeon to Mr. Layton and Assistant House Surgeon to Mr. Massey and later became O.P.O. and House Surgeon to Messrs. Davies-Colley and Brock in 1939. The war interrupted his career but he served with great distinction in the RAMC being made M.B.E. and rising to the rank of Lieutenant Colonel. Although invited by his superiors to make the Army his career he wanted to get back to Guy's to start his training in earnest as an ear, nose and throat surgeon. He passed the final examination for the English Fellowship in 1948 and the London M.S. the following year. The basic skills of ear, nose and throat surgery had been learnt under Mr. Mollison and Mr. Layton but to a large extent it was Mr. R. J. Cann who influenced his outlook and clinical approach.

In 1949 he spent a profitable year in the United States at the Columbia Presbyterian Hospital where amongst other things he acquired his expertise in the Woodman operation for bilateral abductor paralysis of the vocal cords. It was then only a question of time before he was appointed to the consultant staff at Guy's, a position which he held until the end of last year.

"Sam" as he is affectionately known to his colleagues and friends, enjoys a reputation for being a sound diagnostician and a skilled surgeon. His attention to detail both diagnostically and in the operating theatre

The Army pays medical students £3,000* a year. Obviously there are strings.

*Currently under review.

The first is, you must be under 25, with a place at a British medical school.

You'll also need to have passed your second MB or equivalent and a tough Army selection board.

But you'll get £3,000 to continue your normal medical studies. And £7,313 during your pre-registration period.

After that, it's five years in the Army.

You start as a Captain on £9,677. And you'll have the same postgraduate training facilities as in civilian life.

Of course, you'll have to get through Officer training at Sandhurst, and that includes the assault course.

But you'll emerge a lot fitter and, more importantly, a lot more confident about your role as an Army Officer.

However, your training doesn't stop there.

Next, we send you to Aldershot for field training and a run down on what the RAMC does. Then on to Millbank for a short course on the military aspects of the medical and surgical specialties.

After that, it's up to you.

We make you Medical Officer to a Regiment. Which includes looking after the soldiers and their families, rather like a busy G.P.

Of course, you'll have to travel.

Probably to Germany and Ulster. And possibly even Cyprus and Hong Kong.

Finally, you might be worried about continuing your career once you leave the Army.

A tax-free gratuity of between £2,500–£3,500 (approximately) should get you off the ground. (The difference depends on how long we pay you as a cadet.)

If you are already qualified and would like to know about Short Service Commissions and our Vocational Training Scheme for General Practice (Approved by the Joint Committee of Postgraduate Training for General Practice) or Postgraduate Training in Hospital Specialties write to Brigadier (Retd) John J. Voller, MRCS, LRCP, FFARCS, (Dept M10), RAMC, Royal Army Medical College, Millbank, London SW1P 4RJ. Tel: 01-834 9060 ext. 210.

RAMC Officer

are typical of his work, his operations being characterised by a meticulous technique. Although brought up in the hammer and gouge era he quickly showed himself to be adept with the drill and operating microscope. Countless generations of students and registrars are grateful to him for his teaching, which is noted for its clarity of expression and a special talent for illustration. It might be said, however, that his most devoted admirers are his patients for whom he showed unfailing kindness and courtesy. For a number of years he has served the Commonwealth Foundation as a regular visitor to their school for the deaf in Malawi which he helped to set up and which under his tutelage has become a flourishing concern. It was inevitable that he would ultimately become President of the Section of Otolaryngology of the Royal Society of Medicine, followed in quick succession by his appointment as President of the British Association of Otolaryngologists.

In December 1978 several generations of registrars and former consultant colleagues and their wives attended a dinner in the Roben's suite to mark the occasion of his retirement from the staff of Guy's. He continues to be active in his retirement, the link with Malawi being maintained, and he has kindly agreed to look after the Mollison Library for the E.N.T. department.

We wish him many years of happy retirement.

Obituary

Miss S. M. EVANS, S.R.N., S.C.M., M.C.S.P., T.M.M.G., T.E.T.

Sybil May Evans died at Bury St. Edmunds on September 18th 1979, twenty years after her retirement from Guy's.

Originally trained here as a nurse, she entered the School of Massage and Remedial Gymnastics in 1928. After qualifying as a

physiotherapist, she went on to become a teacher under Miss Hester Angove, whom she eventually succeeded as Principal in 1936. She was instrumental in combining the School with the Electrotherapy section of the Light Department and developing the Physiotherapy School as we now know it.

During 23 years as Principal, Miss Evans became a major figure in the physiotherapy world, both in this country and abroad. She was an elected member of the Council of the Chartered Society of Physiotherapy, its vice-chairman for six years, and ultimately a Vice President. She was the first physiotherapist to be invited to give the Founders' Lecture at the Society's Congress, and at the World Confederation Congress in Paris, she read a paper on physiotherapy in heart surgery. She also advised the Nigerian Government on the possibilities of setting up a training programme and following her recommendation a School was established at Ibadan.

After her retirement, Miss Evans continued to maintain close links with Guy's and was an active President of the Physiotherapists' and Radiographers' Association until 1971. The difficulties of travelling between her Suffolk home and London had reduced the frequency of her visits latterly, but her interest was unabated and she was a regular correspondent.

Physiotherapists both from Guy's and elsewhere will have been saddened by her death, but they will be cheered by warm memories of a charming, elegant and brilliant woman.

R. J. C.

M. J. W. writes:—

Sybil Evans was a gifted practitioner and teacher with a phenomenal memory. She showed great concern for patients, staff and students and, herself keenly interested in new ideas, encouraged them to be forward-looking.

Apart from her work, she had wide interests in the arts. An accomplished musician, she had a beautiful singing voice.

Freshers' Section

The Study of Mankind

by Professor Roger Warwick, Department of Anatomy, Guy's Hospital

Charles Singer asserted, in his "*History of Medicine*", that there are no such things as "subjects", only minds, a dictum which rather takes the "steam" out of any attempt by me to account for the occurrence of my "subject" in a pre-clinical *curriculum* currently consisting of about a dozen examinable 'subjects'. Incidentally, a curriculum, properly anglicized, is a *curricle,* which the O.E.D. also defines as "a light, two-wheeled carriage, usually drawn by two horses abreast". Sir Thomas

Browne (of the *Religio Medici*) lugubriously states that "Upon a curricle in *this* world depends a long course of the next". Of course, in the past the pre-clinical carriage was two-horsed,—to wit, Anatomy and Physiology, Structure and Function. But much has happened since then. Even if we omit the invasion of these 'normal' studies by Pharmacology (with its inroads into Physiology and Bacteriology), the study of the normal human being in medical schools has been extended, most desirably, by the development of additional disciplines. Moreover, at some stage the developing 'medical mind' must diverge from the study of normal to abnormal humanity and, indeed, to therapy in *all* its permutations. To smooth this transference a progressive invasion of the 'normal' disciplines by the 'abnormal', the pathological, has occurred in this and other schools. While this is probably best for most students —it certainly helps to maintain the attention of some kind of mind through their 'normal' studies, the inevitable complication of the pre-clinical period, with its multiplicity of teaching interests and examinations, does impose new stresses and dangers, and some students may at worst become much confused and even over-stressed. Teachers in general tend to canalize their own thinking, both in courses and examinations; certainly they are not seen by the student body to be particularly aware of disciplines other than their own. It is therefore not inappropriate to remind teachers, as well as their students, that the preclinical period does in the ultimate concern human beings, in their entirety. If we analyze (or *anatomize*) their structure, starting from the whole body and extending through dissection, microscopy, and electron microscopy, we call this Anatomy; but such lead us directly to Biochemistry. When we consider these structures in the temporal sense, through their functional changes, we are in Physiology. Just so also, Growth, Reproduction and Development are all physiological events in anatomical structures. Some aspects of the function, especially of the whole creature are called Behaviour, though they also are within the ambit of anatomists and physiologists. One large aspect of behaviour is dubbed Psychology, and if we turn from the individual's solitary behaviour to his interrelations with others we come of Sociology and Statistics.

But all these *–isms* and –ologies (and many others) are merely parts of a continuum of knowledge about mankind, and medical minds cannot have too much of any of them. We are, of course, all limited to how much we can absorb or understand—but there should be no ceiling to our endeavours. Mankind is to all of us naturally the most fascinating of studies, and medical students have perhaps the best and broadest of opportunities in the whole university system to exploit this interest. Seen in this way our multi-disciplinary course may seem less forbidding. So use your highly specialized teachers to the utmost; exploit their canalized interests. Some may surprise you by their awareness of other disciplines, though it has to be admitted that a few confine this awareness to the occasional snide remark. You will see through such narrowness. Embrace the whole breadth of your studies in the common aim of understanding Mankind. You will not only enjoy it, you will be able to use it.

Clubs' Union News

By the time this appears I hope all the new students will be beginning to feel familiar with the Guy's campus. Freshers' week was a frenetic but very welcome introduction to the School, the Hospital, the Clubs' Union and its constituent clubs, although you will of course continue to learn about the place for the next five years. This last Freshers' week was the best one I can remember and we should be grateful to all those people who put so much work into it. Notably *Mark Powlson* should be praised as he co-ordinated the whole affair.

The week gave us an opportunity to revive some entertainments that have been sadly wilting at Guy's over the past few years. The success of the Tower Theatre for film presentations (although the sound quality was a little disappointing) ought be followed up. But it would be welcome if some enthusiasts approached us so that it was not the Clubs' Union but rather a proper film society that ran the show.

The success of the dance on Saturday night and of the Boat Club Hop the next Friday is a reward for the work that was done by the Social and Bar Secretary to make a bar upstairs in the North Common Room a viable proposition. Hopefully there will now be a string of Friday night dances run by the Clubs and featuring a band, which should be a very useful money spinner for them as well as providing good entertainment for all of us.

Following the example of a night in Charities Week, a Real Ale Night is being organised, again for the near future. The Charity Week organisers are now beginning to get into gear and would welcome any new faces for ideas and of course helpers. So come along to their well publicised meetings or leave a note for "Charity Organisers" in Boland House.

On the catering front the near legendary meeting of the Hospital and School actually occured late in September. At first it seemed that a stalemate was inevitable as the school refused to recognise their subsidy for catering, and refused to pay the Hospital a similar subsidy. However, after some perseverence we eventually agreed to avoid any duplication of the facilities and to achieve a sensible amalgamation would be in all our interests. Exactly as one would expect it was the financial arrangements that received the most careful consideration. The outcome of the meeting was that the draft amalgamation scheme suggested by the hospital catering function was not approved in detail, but it was agreed that the hospital be invited to re-draft a scheme in which the Medical School Snack Area be retained and the Boland House outlet altered. The most important constraint on the new system will be that Boland House will offer a different style of food service from the Nurses' Home and the Tower and that its accounts will be prepared separately from the "hospital outlets". Students and all staff will be welcome in all of the canteens. Whether anything comes of all this or not, the confrontation between the School and the Hospital helped dispel some myths and certainly cleared some of the fog that has beset this issue for years past.

At the last Athletics Committee meeting a letter from Dr. Mike Hutchinson (our very popular staff affiliate to the Clubs' Union presently in Chicago) was read out. In it he bewailed the fact that it had been all but impossible to convene a meeting of the Blues Committee in the last term. This Committee is (obviously) the one responsible for recommending sportspeople for the coveted blue and half-blue awards. The people who sit on it are all blues themselves and it seems a shame that because of a communication failure or because of apathy the system is not working as it should.

Just before this *Gazette* is due to come out there will have been an Extraordinary General Meeting of the Clubs' Union called with respect to representing the views of Guy's Students at a demonstration against the Corrie Bill on Abortion Law Reform. There is at present a constitutional sub-committee sitting which is likely to recommend that we elect a representative council which will be responsible for policy as well as other business. The restrictions for calling Extraordinary General Meetings are likely to be relaxed as well. This committee was set up (as published in the July *Gazette)* because of the lack of interest shown in Union General Meetings and our apparent inability to run the Union properly under the present system. But perhaps the calling of this Extraordinary General Meeting marks a turning point in the level of Guy's apathy to external representation, policy formation and Union Meetings in general. At the very least it will be interesting and will give those of us on the constitutional sub-committee food for thought.

Chas Newstead.

Cuckulidian Aesop, a Medical Fable

by D. Corless, M.B., F.R.C.P., Consultant Physician, Guy's Department of Geriatric Medicine

There was once a starling, well versed in the art of healing his fellow birds though he had a preference for healing the bones of the young who frequently fell from their nests when learning to use their wings. He acquired much fame and was known far and wide (well, as far as the boundaries of the large wood in which they all lived). Many grateful birds rewarded him well for his skills and he had a large consulting nest in the most private part of the wood which was called Avia Highly. The years passed and many were the fledglings who had been cured by the magical skills of Mr. Starling.

There came a day when Mr. Starling was visiting his other consulting nest deep in a most unattractive part of the wood. Matron Owl, a most wise old bird and Mr. Sparrow, his apprentice, conducted him on his round. The first bird had recovered from a fractured wing but she was no longer in the first flush of youth and Matron Owl had to point out that her wing had been so long in healing that her nest had succumbed to dry rot. Matron Owl suggested that Mr. Rook, the nesting manager, be contacted to see about nest repairs or renesting. There would be a long delay so she had to stay in the consulting nest. So it was with the

next bird and the next bird and so on. "Where are all those nice fledglings I like curing" said Mr. Starling, "all I seem to do these days is look after cuckoos"[1]—for such were the unfortunate sufferers whose wings took an unconscionable time healing, often due to peculiar technical problems such as infection, pain and the slipping and sliding of the clever technical devices that poor Mr. Sparrow was learning to insert.

Matron Owl spoke thus, "You must realise Mr. Starling, that the world has changed. Social conditions in the nests of blackbirds, thrushes, sparrows etc. have improved greatly. Mrs. Dove and her community workers have installed safety rails, instituted a co-ordinated programme of flying training, particularly after the Jonathan Livingstone Seagull[2] affair, advised cuckoo birth control and thus we do not see illness in young birds. Only the poor old cuckoos have accidents these days because they have to live in old unsafe nests."

Mr. Starling was not impressed by such logic and commanded "Send all these old cuckoos home. There is no place for them in my acute consulting nest".

So it happened, with Mr. Starling rejoicing and waiting for an influx of nice fledglings. A few fledglings with non-accidental injuries were admitted, for their parents were mightily upset because they had no community support. Mrs. Dove and her helpers were now too busy with the task of looking after the discharged cuckoos, many of whom were unable to fend for themselves because their wings had not gained full power. Worse, Mr. Rook was quite unable to cope and cuckoos fell through their nests because of dry rot and had to be healed yet again by Mr. Starling who was not pleased by the fact that his nice empty consulting nest was once again full of poor suffering cuckoos.

"Perhaps you will now listen to what I say," said Matron Owl. Acute illness in fledglings is almost a thing of the past. We now have to look after poor old cuckoos and I think we should learn how to do it properly[3]".

"Hummph" said Mr. Starling.

Clearly those who live in a world of illusion must eventually face reality.

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Terminal Care - What Are The Options?

by Mark D. Stringer, Medical Student

St. Christopher's Hospice, Sydenham

Introduction

Terminal care is an important and expanding area of medicine but a relatively neglected aspect of medical education. The sheer size of the problem alone justifies its inclusion in basic medical training such that doctors have some knowledge of the options for the dying patient and an understanding of how to control symptoms.

One-fifth of all deaths in England and Wales are from neoplastic disease and more than 95% of these occur in the middle aged and elderly, who form an increasing proportion of the population. Deaths from cancer have been increasing annually, and in 1976 there were more than 126,000 deaths attributed to neoplasms in England and Wales. Terminal care refers to the care of patients whose death is probable in the relatively near future and for whom medical effort has turned away from therapy and become concentrated on the relief of symptoms such as pain and on the support of the patient and his or her family.

Over the last two decades, an increasing realisation of the distinction between "cure" and "care" in medicine has been paralleled by a growing interest and research into terminal care. [2, 3] During this period, St. Christopher's Hospice, Sydenham and other establishments have evolved to care specifically for the dying. The idea of an institution for the terminally ill, however, is not a new one; terminal care for the indigent sick was the motive underlying most early hospital foundations, including Guy's, and it is only comparatively recently that a hospital has been regarded as "a place where you go to get well."[4]

"Unhappily, the terminal stage could also be defined as beginning at the moment when the clinician says 'There is nothing more to be done' and then begins to withdraw from his patient." This statement by probably the most experienced of all in the problems of terminal care, Dr. Cicely Saunders, clearly reveals the void that follows therapy for many patients. But it is possible to do as much for the patient at this time as ever before, providing both the concern and care and the technical skills required. Pain relief is a major part of the management of terminal disease but control of other symptoms such as anorexia, nausea, dyspnoea, depression and anxiety are equally important,[5] and need to be carried out in conjunction with good nursing care and attention to the patient's social and spiritual needs. From the psychological standpoint, the question of what, when and how to tell the patient and his family are important areas for the doctor, together with support of the bereaved.

This article is mainly concerned with terminal care at an organisational level; each of the major existing alternatives for the dying patient will be discussed, followed by a brief look at their inadequacies. Educational aspects will be mentioned in order to suggest how the present neglect might be replaced by a more positive and exciting approach.

The Options

To look at the existing options for the terminally ill in perspective, an analysis of where cancer patients die is useful (Table 1).

Cancer deaths—where they occurred (%)

	Total in 1000's (and % of all deaths)	Home	Hospital*	Other
1965	107 (19%)	37	60	3
1970	117 (20%)	33	62	5
1976	127 (21%)	30	65	5

*Non-psychiatric including NHS and non-NHS **Table 1**

It is clear that about two-thirds of all deaths from neoplastic disease occur in hospital and this proportion has been increasing as the number of people dying at home has been declining. Furthermore, it has been calculated that only about 10% of cancer deaths occur in non-National Health Service (NHS) institutions, which include hospices and private homes.[6] How successful are each of these alternatives i.e. home, hos-

pital or other institutions such as a hospice, in providing total care for the terminally ill; namely coping with physical, mental, social and spiritual pain?

The Hospital

It is rare for a District General Hospital to have a section set aside for the terminally ill; this is generally intentional to avoid the reputation of a 'death ward'.[6] However, experience at hospitals where such a ward exists has repeatedly shown that this image may be overcome by a good reputation for nursing care and symptom control. Besides, is this worse than the screened bed or single room at the end of the ward where the dying patient is often isolated? A specialized unit directed towards care of the terminally ill can provide a useful nucleus of knowledge and resources together with a peaceful and unhurried atmosphere for the patient and his family. However, a specialized unit is not the only answer to good terminal care. For example, it may often be better to accept a terminal patient back into the care of the familiar team that was concerned with his or her previous management. (The Hedley Atkins Breast Unit occasionally accepts a patient in this way).

A third alternative for the District General Hospital has been the very successful Terminal Care Support Team at St. Thomas' Hospital, London, set up almost two years ago and pioneered by Dr. Thelma Bates, a consultant radiotherapist and oncologist.[7] The aim of the team has been to improve the care of patients dying of cancer[8] and its members comprise three doctors, two nursing sisters (one hospital and the other community orientated), a social worker, chaplain and secretary. Advice on symptom control, particularly chronic pain, is its main function but it also acts to support the patient and family. The Team is careful never to take over the management of patients, has no beds of its own, and receives all referrals through consultants or G.Ps. The patients are visited daily during their stay in hospital and provision for follow up at home is made if the patient and G.P. wish it. There are usually 10 or more hospital patients and about 40 community patients at any one time. Bereavement counselling is also part of the Team's commitment. The Support Team was rapidly accepted at St. Thomas' partly because some patients benefited so much from skilled control of their previous distress, that against all expectations, they were able to return home and partly because of the ease with which their extra knowledge was assimilated into ward routine. The Team also makes use of its potential for teaching; initially nurses, then housemen and finally medical students will have benefited. Doctors can also obtain information in an emergency from the on-call service. The Terminal Care Support Team is probably the most economical and direct way of providing the dying patient and family with specialized care in the wards of a general hospital and of disseminating such experience.

Apart from the general and geriatric wards of a District Hospital, where most cancer patients die, there are the cottage hospitals and, more recently, Continuing Care Units. These are both maintained by the NHS and liaise with local G.P.s or hospital physicians.[2]

The Situation at Guy's

Facilities at Guy's for terminal care are lacking, but the problem is large. A survey of the 532 adult patients in Guy's (excluding Obstetric

and Psychiatric patients) on the 14th September 1979 revealed 31 (5.8%) patients who could be considered 'terminal' i.e. receiving no more than palliative treatment for extensive malignant disease and whose death was considered probable within the following two or three months by senior nursing staff. Not only is this a sizeable proportion of in-patients but the problem is compounded by considering their management. Seventeen patients (55%) from this group were receiving either no analgesia or p.r.n. (as required) medication; the latter was often distalgesic or dihydrocodeine and was rarely made use of more than once a day. Since up to half of all cancer patients experience little or no pain[9], it is possible that these patients were in no need of stronger or more regular analgesia, but this was not borne out by asking many of them. It is now well established that the basis of good relief of chronic pain is regular, usually four hourly, oral dosage with an adequately potent analgesic; titrating the patient with increasing doses controls pain effectively whilst leaving him relatively alert.[10] Ineffective pain control may be due to the patients' unwillingness to ask for p.r.n. analgesia, or to doctors' reluctance to prescribe powerful opiates or uncertainty about how best to provide them. These difficulties might be avoided by more undergraduate teaching on terminal care. (A very useful guideline entitled "Drug Control of Common Symptoms" is available from St. Christopher's Hospice[5])

At Guy's, Sisters Fabricius and Hanrahan, both experienced in the field of terminal care, attempted to set up a small unit designed to meet the needs of terminal patients within the hospital since they feel that there are deficiencies at present. Unfortunately there was insufficient support for the scheme. Furthermore, an existing facility may shortly end; namely the nerve blocks performed by Dr. Hellewell to control some patients' chronic pain. In view of the obvious need at Guy's and the current financial limitations, wouldn't a small Terminal Care Support Team be feasible?

The Home

Supporting the relatives in caring for the dying patient at home involves the family doctor together with local and health authority services. The district nurse is a central figure in this team since she provides nursing care, maintains morale and initiates changes in treatment. A close link often exists between community services and hospital or hospice and the latter may even offer training schemes for district nurses and G.P.s. In addition to the usual local authority services such as home helps and meals-on-wheels, some areas provide night nurses (from the Marie Curie Foundation) and laundry/incontinence services. Social workers assess the need for financial, psychological and practical support to the family and by providing such items as walking aids and commodes, they can prolong mobility and prevent bed sores.

Relatives and neighbours need encouragement and information about the illness and available resources together with the assurance of an emergency help service. They may be entitled to financial aid/or help from voluntary organizations.[2] To be a practicable option for most patients, home care needs the support of an in-patient unit which is willing to cope when the family cannot or when the patient's symptoms become uncontrollable; such a unit may also provide a valuable domiciliary service. [11, 12]

To be at home is often what the patient and his family want, but the burden on the relatives can be enormous; in one retrospective study, one-third of the families interviewed described home nursing as being difficult to the point of becoming intolerable.[13] Indeed, the possible decline in family care might be because relatives are fearful of nursing difficulties and of problems in relieving pain.

The Hospice

The modern hospices started to develop at the end of the nineteenth century because patients frequently received **too little** treatment; in contrast, today the stimulation for some of the hospices has been **too much** or inappropriate treatment.[2] The hospice movement reflects the increasing concern with death and dying which has paralleled a growing awareness that postponing death may act only to prolong suffering.[14] The following outline of the specialized care available at St. Christopher's Hospice, Sydenham, is intended to illustrate what can be offered by a good hospice. However, the latter is only one of the 40 or so homes and hospices in Britain[12], all of which have developed outside the NHS, to fulfill the needs of dying patients.

St. Christopher's, founded in 1967, mainly provides for patients suffering from advanced malignancy, and has both in-patient and out-patient services. Patients are admitted at the request of their doctors, either from hospital or home. Admission may be precipitated by intractable symptoms, breakdown of the family situation or lack of appropriate services. The domiciliary team may initially visit the patient to assess and possibly readjust the existing arrangements so that care can continue at home, or the patient may be admitted immediately, or an alternative unit suggested.

The new patient arriving at St. Christopher's is welcomed by the ward sister at the ambulance and transferred in a warm bed to the ward, where the doctor is at hand if the patient is in pain. The family is interviewed, not only to determine the patient's condition but also to reassure them should they feel anxious about the patient or feel that their own care has failed. Following a comprehensive assessment of the patient's problems which might be physical, mental and social, measures are taken to deal with each of them: pain and other symptoms are treated; gradual and gentle discussion about death is tailored to the patient's need as judged by his comments; difficulties within the family may be helped by nursing staff, social workers, the chaplain, etc. Attention to all the problems can often assist pain control, since the threshold of pain perception is influenced by psychological and physical factors.[2] On the question of "telling the patient", several studies have shown that most patients are more aware of their diagnosis and prognosis than those around them realize,[15] and the opportunity to discuss this can be a welcome relief to the patient and family. However, some individuals prefer to avoid the subject and in fact, half the patients at St. Christopher's never raised the issue of their prognosis.[14]

One of the most important components of care in a hospice is time; the higher than average staff-patient ratio means that the atmosphere is unhurried and there are always people with whom the patient and family can discuss their fears and worries. Another important feature is that the caring team is headed by nursing staff.

Although the emphasis in a hospice is on care rather than cure, the patient's condition is continually reviewed, and a stage of remission in the disease may well indicate further active treatment. Furthermore, the main length of stay at St. Christopher's is about three weeks[12] and although for most this represents the end of a terminal illness, about 12% of patients are able to return home following rehabilitation. They are then visited regularly by the domiciliary service.

Hospice care does not cease when the patient dies, but contact with the bereaved is maintained by arranging visits to the hospice, sending remembrance cards and so on. This is only logical if the family, rather than the patient alone, is seen as the unit of care. Finally, the hospice is actively concerned with research (especially into the control of chronic pain) and education.

The Need for Changes

Terminal care is thus provided at present in hospitals, homes and hospices or similar institutions; it is not my intention to suggest that one or other of these should be the prime place for the dying patient, but more that they are **all** necessary and complementary because they serve different functions. However, it is interesting to point out the reasons why some authors argue that hospital is not the right place for the slowly dying patient. [2, 9] Firstly, a hospital emphasises diagnosis and treatment and consequently there is often a dilemma in knowing when to shift from cure to care. Secondly, there is usually much necessary activity in a hospital and a terminal patient can make heavy demands on the time and energy of medical and nursing staff. Thirdly, it costs only half as much to keep a patient in St. Christopher's as it does in a London teaching hospital.[6] What is urgently needed at present is the application of the knowledge gained from the hospices and other researchers, to the hospitals and the community, as far as is possible given available resources and staff. The Terminal Care Support Team demonstrates how it is possible to do this within the mainstream of a general hospital's daily work.

The first essential of terminal care that needs improving is adequate symptom relief. In a recent retrospective study in which people were interviewed a year after the death of their spouses from cancer, it was found that 29% of home-centred patients were said to have suffered severe and mostly unrelieved pain during the final phase of their illness, compared with 20% of hospital patients and 8% of hospice patients.[16] (this difference in spite of the fact that patients referred to a hospice are very likely to be suffering from problematic pain[2]). Similarly, Hinton found a disturbing amount of unrelieved physical distress, depression and anxiety among patients dying on the wards of a teaching hospital.[15] Fifteen years later the situation has not changed much.[17 18]

Secondly, relatives should be more involved and informed than at present in the case of patients dying in hospital. In the community, the family is involved by necessity, in a hospice it is encouraged but in a hospital it is comparatively neglected. Bereavement counselling follows a similar pattern.

Terminal patients at St. Christopher's are significantly more likely to remain mobile compared to those dying in hospital[14] and mobility also

contributes to morale. Just because a patient is slowly dying it does not necessarily mean that he is bed-ridden; where possible he should be encouraged to get up and about and even visit the local pub or shop. But again this requires time from staff who are often too busy.

Community services could be improved by extending domiciliary visiting, out-patient and on-call services and increasing the sources of advice on management problems available to G.P.s. It appears that these needs are being increasingly met by hospices.[19]

Finally, there is the need for continuing research. Only comprehensive enquiries will reveal how much the NHS is meeting the needs of the terminal cancer patient and his family; it is certainly felt that much more could be done within the NHS without great cost.[20]

Education

There is a growing feeling that care of the dying is inadequately covered in the basic training of both doctors and nurses [20, 21], yet it has been shown that terminal care forms a sizeable part of a hospital's workload. A British Medical Journal leader last year pointed out that "More emphatic teaching needs to be given about the use of drugs as well as psychological support."[20] Nursing courses are now available on this subject and the hospices also provide opportunities for medical students and doctors. But terminal care still often remains a relatively neglected issue within hospitals possibly because death is regarded as a failure or because doctors feel it should be the work of special units. Furthermore, students and staff may find the subject uninteresting since it does not have the excitement of acute medicine. But it is far from dull. Terminal disease provides an excellent opportunity for learning about analgesia for chronic pain; control of dyspnoea, vomiting, anorexia, constipation and so on; radiotherapy, chemotherapy and surgery; pathology of malignant disease and last, but not least, social and emotional support of the patient.

There is very little clinical teaching on terminal care at Guy's (a visit to St. Christopher's Hospice is organised by the general practice team) but the preclinical students have had some teaching by Dr. Parkes, consultant psychiatrist at St. Christopher's, in the last two years. Once a cancer patient on the ward becomes terminal, his management is not usually discussed on teaching rounds and this is seldom because he is too ill. Terminal care is an emotive subject and prone to exaggerated appeals, but it is clear that more needs to be done for the dying hospital patient and this could be achieved in part by a modest increase in awareness of the problem in clinical teaching.

Conclusions

Terminal care occurs in hospitals, homes and hospices or similar institutions. The attitudes and skills of a hospice demonstrate what can be done to alleviate pain and suffering and how it is possible to substitute security and peace. Moreover, extension of these practices to hospitals and the community will help to erase the fears that commonly surround death today; namely the fear of pain, the fear of pain relieving drugs swamping the personality or producing dependence, the fear of isolation and being kept alive by technology.[2] The provision of terminal care requires both skill and a change in our criteria for success with

patients, which is possible only through wider education and awareness. As one writer in this field has pointed out[6], 'while "good health" may be the aim of a State for its population or a family for its members, a good death is not yet in the same category.'[6]

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Euthanasia, Can Legislation Be Avoided?

This topic was discussed by the London Medical Group at Guy's on October 11th. Professor R. B. Zachary from The Children's Hospital, Sheffield, considered that the desire for euthanasia was a response to painful, protracted, terminal illness. He felt that a wide application of the known methods of controlling pain and a greater understanding of associated psychological and spiritual problems could prevent any trend towards legislating euthanasia. He distinguished between active and passive euthanasia—the latter referring to the NTBR (not to be resuscitated) patient where treatment is withheld—but was opposed to the legislation of either. Dr. C. Brewer, a Consultant Psychiatrist from Birmingham and a member of the Euthanasia Society admitted to a confrontation with the Public Prosecutor following a failed attempt to overdose a terminally ill patient. He insisted that he was only doing what many other doctors are currently practising and felt that a law was necessary to remove the dilemma facing them. People should be able, he said, to state in a time of reasonable health whether they want to die under certain circumstances and be able to revoke this decision at any time.

"Dr. Brewer has confessed to attempted murder!" So began Lord Justice Lawton, who went on to say that there is no defence for euthanasia under the law even if the patient has consented, though in practice, courts tend to be very lenient. He refuted the surveys claiming that 60% of public opinion is in favour of voluntary euthanasia but unfortunately was unable to support this with more than personal experience.

Is legislation therefore the answer, or do we need to re-examine the reasons why euthanasia is desired?

M. D. S.

Outside Guy's—Continuing our occasional series in which people explain the fascination they find in their hobbies.

The English Parish Church

by Harry O. Brunjes, Medical Student

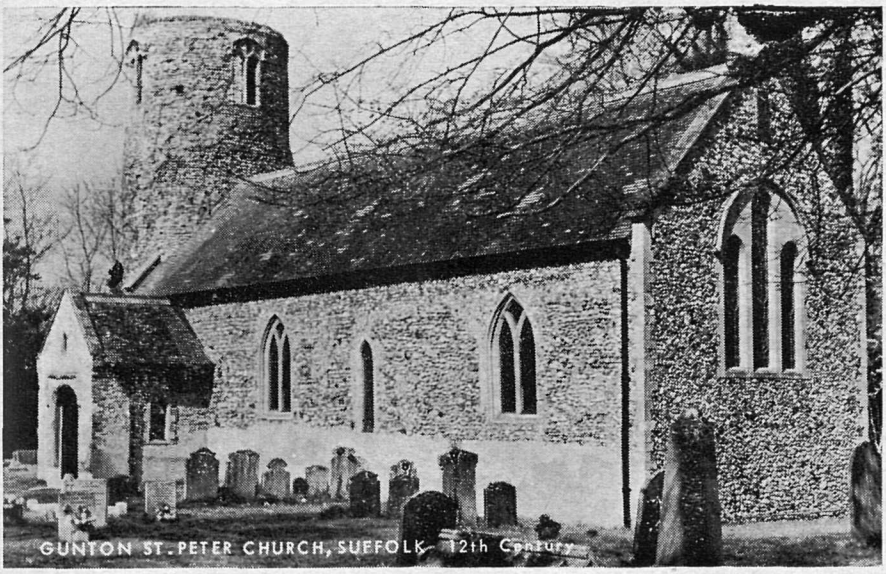
"Stands the church clock at ten to three and is there honey still for tea . . ."

During lonely, desolate months in first world war trenches, Rupert Brooke thought and wrote of his home, his village and his local church. Like everybody else he had an attachment to his church. There must be very few who don't have some affection, some belonging, to a church somewhere. Maybe it is a religious connection or just a happy memory of childhood, but whatever the reason the church is yours, as important to you as generations before you and doubtless many generations to come. Many years may separate your visits but although all else alters the church remains constant, unaltered and oblivious to the passing

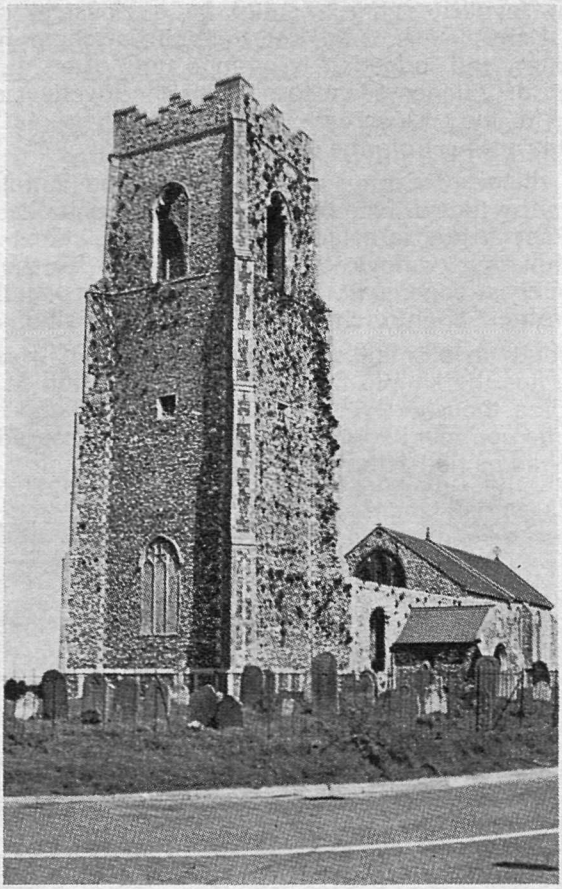
decades. Your favourite church could be a classical masterpiece in some industrial city centre or the soaring spire of some gothic gem in a sleepy backwater, and indeed it is strange how often the smallest and most neglected of villages seem to possess the loveliest of churches. A recent article in the *"Observer"* referred to them as the image of England and it is not far from the truth.

My own village of Corton on the Norfolk and Suffolk border, with its accessability by foot or bike to many medieval churches, first aroused my interest. East Anglia is a land of gentle undulations with pleasant variations of hills and valleys, the perfect setting for the most perfect of churches. Only a short walk from our house outside the village are three of the prettiest country churches I have ever visited.

To the south in a small clearing in the distant woods on the old Gunton Estate lies the simple Saxon church of Gunton St. Peters. It has stood there for a thousand years but it is now isolated and is the last remains of some community which apparently disappeared in the middle ages. Gunton was named after an old Saxon chief, Gunni.



To the north on the cliff beyond the village on the coast road lies the old parish church of St. Bartholomews, proudly standing over the North Sea literally yards away. It, too, is now isolated, and is a reminder of a former village. Its loneliness is made more pronounced by its gigantic tower which for centuries housed a beacon. A welcoming sight for returning homesick fisherman, it provided safe navigation into the Stanford Channel leading into the home port of Lowestoft a few miles down the coast. Sadly, the roof of the nave was damaged during a severe storm in the last century and now only walls separate the chancel and altar (which now acts as the church) from the tower. However, it is still a most impressive sight and one of the best known landmarks on the coast.



The Tower of St. Bartholomew's, Corton.

A walk inland lies the rural village of Blundeston, and its beautiful parish church. It is an ideal village and little altered since the days when Charles Dickens wrote David Copperfield, based on the village, the surrounding countryside and coast, whilst resident at the rectory. As a schoolboy, reading about an actual church which was only in the next village gave the book a realistic quality which for me has never been equalled, and even now it is easy to spot the characters of Barkis, Peggoty and the like in the present locals of the village as they gather for church on Sunday and lunch at the *Old Plough* afterwards

Churches have for centuries been the focal point of the communities they serve. In each succeeding age many of the greatest talents from the genius of a Christopher Wren to the village mason have been employed in their design; much of the finest craftsmanship has been lavished on their adornment and a great deal of time and energy put into their

The Dickensian
Village of
BLUNDESTON
Near
Lowestoft
C. W. Walker
1928
The Church
(with 10th Century
round tower)
so freely
mentioned
in "David
Copperfield,
& famous
sundial above
West Door
"The Plough Inn,"
from here Mr. Barkis,
the old carrier, started
on his journeys
"The Rookery"
Mrs. Copperfield's Bedroom
on extreme left
Charles Dickens
1812-1870

maintenance and preservation. For the enthusiast, a church provides an endless list of features of study and interest. A church can be analysed in its historical, geographical or religious context, and dated and compared in terms of its style, plan, structure, roof, pillars, arches, doorways, windows, porches, altars, fonts, piscinas, paintings, sculptures, furnishings, crypts, crosses and so on. Broadly, churches are classified into three main areas:—

1. Romanesque, from pre-Conquest Saxon up to C1230.
2. Gothic, from C1230–1650. This is a wide field and includes the early gothic, perpendicular, Tudor and early Stuart architecture.
3. Classical Renaissance, which contain late Stuart, Georgian and Victorian eras in buildings.

Function, technological skills, materials and fashion are four basic factors which give the form to any building. Changing fashion in architectural styles was not a feature of early churches, but is very dominant in the Classical Renaissance period onwards. The features, furnishing and ornaments of a church already listed are the diagnostic clues to dating, and with the frequent use in latter centuries of older elements in buildings and ubiquitous Victorian restorations, exact dating of a church can be quite a skill.

For myself, it is the unique points of a church and its part in local history which I remember most. The largest parish church in England overlooks the market square of Gt. Yarmouth. Brighton is proud to boast the tallest church in the country and was actually designed to the dimensions of Noah's Ark. Its fabulous height is incongruous to its neighbouring buildings, and is clearly visible to the east when entering Brighton Railway Station. The oldest four-walled church in England is situated in the middle of the isolated coastal Penhale Sands to the south of Newquay in Cornwall. St. Georges just down from the Royal Sussex County Hospital had Sir Robert Peel and his family as major benefactors. In London there are at least 13 examples I know of (outside St. Pauls) displaying the brilliance of Christopher Wren. Inigo Jones designed a whole mansion involving the Parish Church of Elstow in Bedfordshire. The list is endless all over the country, but nostalgia for East Anglia takes me back regularly many times every year, but still it is impossible to visit half the churches I would like to or have heard about. There are just so many. The Diocese of St. Edmundsby and Ipswich boast over 500 old churches in Suffolk, while in 1975 the Bishop of Norwich in an article referred to 650 Medieval Churches in Norfolk, which is the largest concentration of outstanding ancient churches in the whole of Christendom. An astounding fact! From all the churches I have visited, my favourite is a parish church I have known for twenty years and visited regularly. It is large and ornate, and really has to be visited to be appreciated.

The Holy Trinity Church, Blythburgh, stands behind the village, four miles inland from the coastal town of Southwold on the A12, guarding over Henham Water which flows into the sea at Walberswick. The great size of the church was considered necessary by its 15th century designers to accommodate the parishioners of what was then a town large enough to rate two annual Charter Fairs, its own mint and gaol. It was a big town of houses and market stalls where quays

bordered the river which was in those days navigable as far as Halesworth and the town entertained many crafts from overseas. The town's merchants spent money on the church for three reasons: for the glory of God, for the glory of their families, and more cynically a desire to save their souls. Still, whatever the reason, a beautiful church was the result. Unfortunately they did not know Blythburgh was then at the height of its prosperity and its decline was swift and steep. Bigger ships couldn't navigate the shallower river channels and trade went elsewhere up the coast. When the adjoining Priory was suppressed in 1538 to supply funds for a new college in Ipswich, the Catholic population and their church were exposed to the threatening influences released by the cataclysm of the Reformation. The population fell, the town became a village and now it is just a pretty spot in Suffolk. The many who pass through daily on the A12 do not know of its former glories and know the village probably for its delightful pub with its broadland views and fine Adnams Ales brewed locally in Southwold.

Holy Trinity, Blythburgh.

The church remains as an enormous monument to old Blythburgh and is indeed an awe inspiring sight. It is built on a small elevation to the west of the present village and at night it is floodlit with great effect. Approaching from the north this glowing edifice reflected in the waters below has a mythical, "Brigadoon" like quality. It is as if it was an image reflecting the past and if you were to return the following night it would be gone. Its history is intriguing. Cromwell's men entered the church on horseback and set about vandalising the church. Some locals do not venture near the church on certain nights, fearing the terrifying echoes of retreating hoofbeats. The spire crashed through the roof during a great storm in 1577. According to the records the church was mouldering into a ruin and thirty years later a local newspaper reported that the congregation sheltered under umbrellas from rain pouring through holes in the roof. Finally in 1881 a fund was set up and was the starting point

from which the church has been restored to its former glory. The internal furnishing and ornaments are many and varied, and these combined with the unique view and history make each recurrent visit something special and something to look forward to. There is always a new feature to look upon, or an old one previously missed, and some new anecdote to learn which continue to add to the story of Holy Trinity, Blythburgh.

It is a mistake to avoid visiting churches if you are not religious. When you look at a church you are looking at living history. A tradition dating back over centuries for us to examine and admire. They reflect the growth and evolution of communities over centuries, the changing talents and changing values of the ages. Personally, it is the story of the church and its part in local history which I find most rewarding. An article in the *Observer* looked upon parish churches most romantically and referred to the sense of warmth and continuity a church can provide concluding that as you enter a churchyard you can feel:

"An ageless, serene and ideal England."

Tate Gallery

This gallery has improved since the famous? extension was added earlier this year. From the Moore's outside to the organised functional interior one is immediately reminded of the better foreign galleries of Paris, Florence and Amsterdam etc. The gallery mainly houses work of this century although there are many earlier British works through the ages including Turner, Blake, Hogarth and Constable. The new extension is devoted to contemporary works and it is nice to see a gallery that is prepared to deal with such tricky material rather than spend money on latter day works, only to find that it is still behind times. There are also many classics such as *"The Kiss"* by Auguste Rodin, *"Mr. and Mrs. Clark and Percy"* by David Hockney and Picasso's *"Seated Woman"*.

Royal Academy

Under the shadow of *"The Horses of San Marco"* the Royal Academy has two other concurrent exhibitions. One is about Ironbridge where, historians tell us, the Industrial Revolution was born under Thomas Telford and, others will say, our present day troubles began. It is thus a must for anybody of any viewpoint! The vigour of this period is particularly striking as shown by the tremendous upsurge in technical equipment. The other exhibition is the second Burlington Art Fair—this year housing many works from the collection of Sir Robert Sainsbury, of food fame including, early Moores and the first Giacometti painting. In November the R.A. starts a Post-Impressionist exhibition which I think will be brilliant for it will contain, Van Gogh, Vlamank, Nolde, Munch, Gaugin, Soutine and many others.

Hugh van't Hoff.

Films

"Man of Marble" by Wajda is a Polish version of Orson Welles' "Citizen Kane", focusing primarily on the power of the cinema instead of the press. The film deals with the rise of a bricklayer, Birkut, to Stakhanovite status and his subsequent decline from favour when he questions the authority's brutality to his friend. All this is seen through the eys of Agnieszka, a manic film student preparing for her first documentary, who sees Mateusz Birkut as a symbol of the destruction of people by authority. Thus the film unfolds as a series of newsreels showing various stages of Birkut's career. The clippings of the forties and fifties are in sharp contrast to the present film techniques (eg. the use of wide angle lenses) and show how much more powerful present methods can be. The performance of Jerzy Radziwollowicz as Birkut is excellent in its simplicity, and the film loses little through subtitling. One of the many things that makes this film good is its frankness. It does not shy away from questioning the system and I wonder how such a tender film, both in material and in treatment, could be made behind the Iron Curtain.

Other films worth seeing include the latest Truffaut **"Love on the Run"** (being acclaimed as one of his best works—although only time will tell); **"Manhattan"**—You can always be sure that Woody Allen will be entertaining and this certainly is; **"Coming Home"**, which is probably the best film I have seen this year and **"Woyzeck"** (yes! another Polish film—this time starring someone who looks like a bald Frank Sinatra).

H.v.H.

Nursing

Many people, both nurses and others concerned with the care of patients, are disconcerted or even horrified when they visit a ward where new nursing notes are being used. "What's wrong with the Kardex?", they ask and "Why all this extra paper work?" "Problem Orientated Medical Records are bad enough" is another comment. "Surely you don't have to complicate things even more." I would like to explain why nursing notes are more important than ever before and to justify the new format.

One obvious reason for having good nursing notes is to provide continuity of nursing care. When the day is divided into three shifts and each nurse is on the word for only 40 of the 168 available hours each week, verbal communication alone is not reliable. This problem is going to get worse—we have already been threatened with a 38 hour working week. Another reason is that much emphasis is now being placed on accountability for one's actions, and a signed entry in the nursing notes may be the only proof that a nursing procedure was carried out.

However, there is a third reason, which I believe is equally impor-

tant. It is essential that nurses think logically about the nursing problems of their patients and plan the care to be given. If this is not done, nursing care becomes disorganised and haphazard. It is very easy to think that one has thought about something logically; attempting to write it down soon shows where the ideas are rather hazy, if not totally unreasoned. Problem orientated nursing notes are not just a different way of recording information, they are an attempt to influence the way nurses think about their work.

What then is the logical way to give nursing care? As in any other process it involves: assessing the problems, setting the goals, making a plan to solve each problem and achieve the relevant goal, carrying out the plan and periodically evaluating each problem to see if the plan is working or not. "Too obvious to be worth stating" I hear you say, and "Isn't that what good nurses have always done anyway?" I can assure you that, obvious or not, Stage 4, that is the carrying out of (completely unplanned) nursing care is the only part of this procedure that occurs in some wards. And as for the good nurses who have always done it—I would agree that there are many of these, but what good is a well reasoned plan if it is in a particular nurses head and she is off duty? Another benefit of this sort of planning is that each patient's needs are considered individually, and a patient who is having, say a hernia repair, is not treated like all other patients having hernia repairs if some of his problems are different from theirs.

Much work has been done recently in many centres to develop records on which all the stages of the process of nursing can be written, and to teach nurses to think and record in this way. A working party at Guy's has designed a form, and nurses working in a variety of specialities are using it. I think it is one of the most important and exciting developments in nursing for some time.

Julia Fabricius,
Sister.

Due to difficulties with the Internal Mail we regret that Ronald Cooper's Physiotherapy Column will not appear until next month.

Book Reviews

"Clinical Thinking and Practice—Diagnosis and Decision in Patient Care". H. J. Wright and D. B. MacAdam. Pp. 207. Price £4.95. Churchill Livingstone.

One of the major fruits of academic general practice has been a new level of introspection into the context of clinical medicine. This book sets out to discuss the questions: "Who consults the doctor and why?", "How do doctors think in the clinical situation?" and "How can the logic and effectiveness of diagnosis and management be improved?" Although a book of concepts and ideas, these are built on crisp presentations of the hard data and many chapters abound in realistic clinical examples. The approach is sensitive but not soft, deep and yet concise. The book is aimed at the medical student and the practitioner, and as a clinical tutor, I would strongly recommend it to both.

B. HICKS,
Clinical Tutor.

"Understanding Cardiology", by Davies & Nelson. Pp. 424. Price £16.70. Published by Butterworth.

In the Preface the authors point out that this book is addressed primarily to medical students entering their clinical training and the information provided is

certainly adequate for passing the M.B. examination, and probably the M.R.C.P. also. The book is divided into fifteen chapters each of which describes one aspect of Cardiology, beginning with "Understanding Symptoms" and progressing through subjects such as left ventricular outflow obstruction, left to right and right to left shunts, cardiac arrhythmias and echocardiography. The final chapter on understanding cardiac catheterization is placed too late because most of the other chapters are illustrated with tracings from cardiac catheterizations. There is also wide use of phonocardiograms as illustrations and more explanation of these would be helpful for the medical student.

The actual information in the book is of a very high quality and the approach is as expected from Dr. Hywel Davies whose Cardiology training was in England, including a considerable period at Guy's Hospital. His co-authorship with Professor Nelson of the University of Kansas has resulted in a very successful blend of English and American approaches to Cardiology. The style of the book is clear and even complicated problems are presented in a very straight forward manner, with illustrations of excellent quality. The medical student who has access to this book will find it an extremely valuable source of information about his patients and will be able to understand Cardiology in considerable detail.

EDGAR SOWTON,
Consultant Cardiologist.

"Bedside Diagnosis" by Seward and Mattingly. Pp. 357. Price £7.95. Published by Churchill Livingstone, 1979.

This book was first published in 1949 and over the succeeding thirty years ten further English and seven foreign language editions have been produced. There can be no doubt, therefore, that "Bedside Diagnosis" is a successful book.

It was written for the "medical student and doctor" to "provide a link between the clinician's findings at the bedside or in the clinic and the systematic description of diseases in the more orthodox textbooks of medicine". Each chapter is divided into four parts: firstly, a synopsis of causes; secondly, the physiology of the symptom or sign; thirdly, an analysis of the presenting symptoms to narrow the diagnostic field and fourthly, a description of each cause or disease.

The 26 chapters cover the main symptoms and signs that are encountered in everyday practice. The description of each disease is adequate but in many cases a more detailed analysis of the symptom or sign is required. In addition, although italics are used in the synopsis to indicate which causes are more common or are of clinical urgency, little emphasis is placed in the text on what is clinically important.

The success of this book over three decades indicates that there is a need for such a reasonably priced volume. Without doubt, many students will benefit from its systematic anatomical/pathological approach. However, in its present form I doubt that this book will be quite so helpful to the busy hospital doctor.

ALLISTER VALE,
Senior Registrar in Medicine.

"Cardiology for Students", by Max Zoob. Pp. 319. Price £3.95. Published by Churchill Livingstone.

This is a small but very comprehensive book on Cardiology in which the subject has been dealt with as a series of separate aspects. Separate chapters deal with clinical symptoms and signs, haemodynamics, basic electrocardiography etc. The main cardiac conditions are similarly allocated a chapter each and the format is very similar within each chapter. A short description of aetiology is followed by pathology, clinical features, X-ray, cardiograms, echocardiogram, differential diagnosis and treatment.

The style is clear without complicated discussions of alternative treatments and the book forms an excellent reference source. Its use for students will be in reading about particular aspects of Cardiology which they may meet in the wards. There is considerable more detail than will be required to pass the M.B. exam and the book is up-to-date and comprehensive so that it should be of considerable value for post-graduates also. Dr. Zoob has included some controversial features such as the use of tourniquets to treat left ventricular failure. The general principals throughout the book are to give up-to-date advice and to emphasise safety.

The book is well produced with adequate size print for such a small volume and has good simple line drawings. It is a paper back volume and so the price is commendably low. It forms an excellent basic reference book on Cardiology.

EDGAR SOWTON,
Consultant Cardiologist.

"Psychology in Relation to Medicine", 5th edition, by Mowbray, Rodger & Mellor. Pp. 263. Price £5.00. Published by Churhill Livingstone, 1976.

This is the fifth edition of a book originally published in 1963. It was a fairly poor book then and is now somewhat worse by virtue of the fact that few concessions have been made to the passing of time. Hence topics such as thinking, remembering and perceiving are still churned out in an outdated and muddled way without any obvious awareness of more recent developments in these areas. That this book should have stumbled its way through to a fifth edition would appear to be an indication of its lack of competitors rather than any intrinsic merit it might have.

On the positive side it is fairly clearly written and a couple of chapters get quite close to being interesting. Sadly most of the contents could be gleaned more satisfactorily from a general introductory textbook and while there are some concessions to medicine, many important areas of clinical relevance have been completely overlooked.

I would not really recommend this book at any price but at £5.00 for an uninspired paperback, prospective buyers should be actively dissuaded from considering it.

Dr. JOHN WEINMAN,
Senior Lecturer in Psychology.

"Neurosurgical Nursing Care", by Dinah Van Zwarenberg and C. B. T. Adams. Price £5.95; Paperback £2.25. Published by Faber & Faber.

There has been a need for a book such as this for some time. It gives a fairly simple guide to conditions that the nurse will meet in a Neurosurgical Unit and a more detailed guide to the fairly basic nursing care.

I found the phraseology irritating at times and there was a great deal of "local jargon" used in most chapters. This would be misleading to a nurse working in a Neurosurgical Unit other than the Radcliffe. It was, however, encouraging to see a chapter devoted to the discharge and after care which included both the patient and his relatives and gave some guidance on "how to tell the relatives", something which many nurses find difficult.

D. J. OWEN,
Nursing Officer.

"Colour Atlas of Ophthalmology", by Lim and Constable. Pp. 151. Price &6.50. Published by Henry Kimpton, 1979.

This book is well produced and includes an outline of ophthalmic clinical practice which is suitable as an introduction to the subject for medical students. Its scope, however, is severely limited by its size and brevity and it cannot, therefore, be recommended for those at a more advanced level. It can, however, be strongly recommended as an introductory book for those commencing the Clinical Students Ophthalmology course. Ocular disease is treated topographically under well chosen subject headings. In general the text is clear and concise, and is illustrated with a large number of colour plates. These are of excellent quality but have clearly increased the price of a relatively small volume.

D. M. WATSON,
Consultant Ophthalmologist.

"Haemostasis and Thrombosis. A Conceptual Approach", by J. Hirsh and E. A. Brain. Pp. 103. Price £3.90. Published by Churchill Livingstone.

The preface states that "this visually orientated text has been prepared for use within the self-instructional M.D. programme at McMaster University". The McMaster Medical School established in Hamilton, Ontario, in 1966, and the youngest of the Canadian medical schools, has developed teaching methods and aids which allow the student to cover much of the curriculum by "self instruction". The staff of the new school were carefully chosen for their intellectual calibre, scientific distinction and enthusiasm for teaching their particular subjects. Dr. Jack Hirsh, the senior author of this clearly written and stimulating text is a Professor of Pathology and Medicine, a mark of distinction in both fields. The text has a firm base in physiology and pathology and is clinically well orientated. His co-author, Dr. Elizabeth Brain, is described as Learning Resources Editor, Health Sciences Education, at McMaster University Medical Centre (what position, if any, does this correspond to in a British Medical School?).

The book has evolved from the series of illustrated slide tapes originally made by Dr. Hirsh and is intended to complement the tapes, though in its present form it incorporates the "audio-visual" material and stands on its own. In this way the authors simplify the major pathophysiological concepts involved in

the understanding of normal and abnormal haemostasis and thromboembolism, and they cover the clinical aspects of diagnosis and treatmtnt.

There are eleven chapters: an introduction to normal and abnormal haemostatic mechanisms; clinical diagnosis of bleeding disorders; laboratory diagnosis of bleeding disorders; vascular disorders; platelet disorders; general principles of coagulation disorders; inherited and acquired coagulation disorders; fibrinolysis; and pathogenesis and treatment of thrombosis.

The writing is clear and simple as are the accompanying diagrams. Each chapter ends with some self assessment questions but no answers are given—"they are all to be found in the text". Those who cannot answer the questions to their satisfaction are advised to review the text—and if still having problems, to consult their teachers. Being an admirer of Dr. Hirsh's skills as a teacher and of his distinguished scientific contributions to haemostasis and thrombosis, and what is more, agreeing in large measure with what he says in this book, I would be only too happy to be consulted! Those who have attended the lectures on haemostasis in the Pathology Block Course at Guy's may perhaps get a feeling of "déjà vu" if they read this book—some of the slides used to illustrate those lectures were taken from Dr. Hirsh's publications.

The authors do not pretend to cover all aspects of the field; for disease classification and laboratory procedures other books will have to be read, though only few references are given. But there is more than enough to cover the relevant parts of M.B. Pathology and Medicine. It is a little surprising for a book on haemostasis and thrombosis which gives 1979 as the publication year, that prostaglandins receive only a brief mention, and that particularly the thromboxanes formed in platelets and prostacyclin generated in vascular endothelium, respectively the most potent platelet aggregating and inhibitor substances known, receive no mention. (The discovery of prostacyclins by Vane and his colleagues at the nearby Wellcome Research Laboratories in Beckenham has opened up an exciting field of research.) But that does not detract from the value of this book and doubtlessly the authors will put this into masterly perspective in their next edition. However, it is nice to see mention of kallikreins and bradykinins in their link with the activation of the coagulation cascade and the fibrinolytic system.

For the student (or qualified doctor, junior or consultant) interested in acquiring a sound basis for understanding haemostasis and thrombosis, this book can be thoroughly recommended, and it is remarkably cheap at the price.

P. BARKHAN,
Consultant Haematologist.

"Introduction to General Practice", by Drury & Hull. Pp. 232. Price £3.50. Published by Balliere Tindall.

I liked this modest little book. Sensibly and straight-forwardly written, it covers a lot of ground yet manages to convey much detailed information without obvious strain. It really presents the background to General Practice and the way it works and is not a textbook, though the authors well exemplify their approach to problems and their management by some well chosen and well described case histories. The section on streptococcal sore throat would benefit from revision; it is unfortunate to be specific and inaccurate at the same time.

P. HIGGINS,
Professor of General Practice.

"Scoliosis and Other Spinal Deformities", by Moe, Winter, Bradford and Constein.

The last 20 years have seen the surgery of progressive spinal deformity grow from an empirical art to a well-established technology. Almost all the advances during this time have come from a small group of dedicated, hard-working American surgeons. The success rate following operation on scoliosis was appalling a generation ago. Many patients had several arduous operations and yet remained very deformed. We can now offer most a reasonable chance of control of the deformity.

The senior author of Scoliosis and Other Spinal Deformities, John Moe, is the single most influential figure in the treatment of scoliosis today. His book therefore carries great weight and any surgeon involved in the management of scoliosis must study it carefully. The book has been carefully produced and discusses all aspects of scoliosis. The first few chapters deal with spinal deformity in general terms and include discussion on aetiology. Chapters on special forms of scoliosis then follow before detailed descriptions of therapeutic techniques are given. There are masterly examples of lucid writing and little specialised background is required to make them comprehensible.

In Britain, the treatment of scoliosis is concentrated in a small number of centres and it is only in these that the true value of this book will be fully appreciated. However, most orthopaedic surgeons will appreciate having a copy handy, say in the hospital library, as a highly authoritative work of reference. My own copy is already a treasured favourite and I recommend it most highly to my colleagues.

MICHAEL WATSON,
Consultant Orthopaedic Surgeon.

"The Older Patient. A textbook of Geriatrics", by Irvine, Bagnall and Smith. Pp. 230. Price £2.95. Published by Hodder and Stoughton.

This book is now in its third edition and is receiving its first review in *Guy's Gazette*. The preface to the third edition states that "the trickle of literature on geriatrics has turned into a flood". Thus those with limited means, desirous of acquiring information are faced with a problem—which book? The paperback version costs £2.95 which I hope is a reasonable price for a student nurse for whom the book is written.

The book is written by three people, a physician in geriatric medicine, a social worker and a nurse, but the text does not betray this fact, so smooth is the presentation. The book is in two parts, the first describing the general aspects of caring for old people, the second describing illness in old age. I think the student nurse will find this separation useful though the skills described in both parts become welded together when caring for patients.

The overall impression is of a book designed to engender a caring humane attitude towards the elderly patient no matter whether he be in the department of geriatric medicine, general medicine, surgery or orthopaedics. The layout is compact, though the type is rather small; the illustrations are excellent.

I can thoroughly recommend this book for student nurses and I think it is worthy of a much wider readership, to include social workers, physiotherapists, occupational therapists, doctors and anyone who wishes to grasp basic attitudes and skills necessary to care for ill old people.

D. CORLESS,
Consultant Physician,
Department of Geriatric Medicine.

"A Colour Atlas of Liver Disease", by Sheila Sherlock and John Summerfield. Pp. 272, 554 figures. Price £18.00. Published by Wolfe Medical Publications.

This colour atlas contains a remarkable collection of photographs, bringing together the clinical, radiological and pathological features of a wide range of liver disease. Ultra-sonography and radio-isotope scanning techniques are included where relevant. The test relating to each figure is informative but brief; possibly a little too brief in some areas. The standard of photographs is generally very high—the only exception being some of the low power photomicrographs, which are notoriously difficult to produce to a high standard.

I found this a very easy book to browse through. A minor criticism is that there appears to be some unnecessary reduplication of some clinical features, i.e. numerous examples of ascitic abdomens and pruritic skins.

What is the purpose of a colour atlas? I suppose it serves as a gentle introduction to the subject of liver disease. A parallel could be drawn with modern commercial advertisements dependent for their impact on dramatic colour photographs. Indeed, when the children picked up this book which I had left lying on a chair in the lounge, they were most intrigued by the "rude" pictures!

D. R. TURNER,
Reader in Pathology.

"Cancer Nursing—Radiotherapy." Edited by Robert Tiffany. Price £2.75. Published by Faber.

This book describes in a straightforward way the scientific basis of radiotherapy, its uses, the techniques used for planning and giving the treatment, and the types of nursing care that is needed, all in 104 pages and 7 chapters. It is written by a group of experienced teachers from The Royal Marsden Hospital, as one of a series of books on the nursing of patients with cancer, and the authors show the place of radiotherapy in the management of the different cancers.

The three chapters (5, 6, 7) on Nursing Care are excellent. They are lucid, full of information, and nothing important has been omitted. They are arranged clearly, and it is easy to look up the treatment appropriate to a particular patient. And, for this section alone, the book deserves to be in the library of any ward looking after radiotherapy patients.

The two chapters on the uses of Radiotherapy, its techniques, and the planning of treatments (chapters 1 and 4) are also written clearly, and will show you why a particular technique of radiotherapy is chosen, and how it is planned —and also some idea of what happens to your patient in our department.

Chapters 2 and 3, on the physics and biological effects of radiation, are more difficult. They attempt to summarise into 20 pages some very complex science, and the style is so condensed that I found it unclear until re-read.

But this is a useful, short book, which can be both an introduction to Radiotherapy and also a hand-book for nursing. Unfortunately, there are some careless printing errors—like printing a skull X-ray upside-down!

"Psychiatry", by W. H. Trethowan. 4th Edition. Pp. 448. Price £4.50. Published by Balliere Tindall.

It is good to be able to report that the student now has several first class textbooks of psychiatry from which to choose. This is one of the best. It was originally, Anderson, then Anderson and Trethowan, now Threthowan; Anderson was Professor in Manchester and Trethowan is Professor in Birmingham, though with strong Guy's connections. Both Professors espouse an unshakeable belief in the vital primacy in psychiatry of careful clinical interviewing and observation, leading to the accurate and compassionate identification of symptoms and signs—which in psychiatry many prefer to call phenomena. Hence the strength of this book is its sections of clinical psychopathology (=phenomenology), with excellent descriptions of delusion, hallucination, delirium, phobia, etcetera. I find the book eminently readable too, though every student must judge by browsing whether a particular style suits him.

This book is spoiled for me a bit by three things—it advocates a classificatory system which is somewhat idiosyncratic and therefore misleading; it presents a muddling outline of the admittedly difficult neuroses (which it rechristens) and personality disorders, potentially misleading even though the individual clinical descriptions are excellent; and it is more sketchy than I would have wished on psychological treatments. But the student should nevertheless consider this book seriously along with Fish, Stafford-Clark and Smith, and Curran, Partridge, and Storey.

J. P. WATSON,
Professor, Dept. of Psychiatry.

"Aspiration Cytology of the Breast", by Dr. Hubert Schöndorf. Pp. ix+14. Figs. 92. Price £27.50. Published by Saunders, 1978.

While diagnostic exfoliative cytology is a method of proven value for the recognition of both infiltrating carcinoma and pre-carcinomatous epithelial changes at a number of sites, the cytological study of cells aspirated by syringe from solid and cystic lesions of the breast is still at the stage of critical evaluation. This monograph from Frankfurt gives a clear picture of the present situation.

The technique emerges as a most valuable one in skilled hands, but one that is inherently unlikely ever to achieve quite as high a degree of precision as histological examination in the diagnosis of malignancy in the breast. Tumour cells may be difficult to obtain from small-celled scirrhous carcinomata. Because the malignant cells are seen out of their normal context with the tissues, the method does not discriminate between intraduct (*in-situ*) and infiltrating neoplasm. Furthermore, because some cells are of equivocal significance, a small proportion of smears—as with cytology of other sites—are inevitably scored as "suspicious", while all the published series quoted include examples of false positives and false negatives (in the author's series both these categories account for 3 per cent of the specimens). He recommends that an unequivocal cytological diagnosis of malignancy should be confirmed histologically with a biopsy.

The author uses two staining techniques—a Romanowsky method (May-Grünwald-Giemsa) applied to air-dried films and the Papanicolaou technique on fixed smears. Most of the colour plates are photomicrographs of films prepared by the former technique: the minority, stained by Papanicolaou's method, show greatly superior nuclear detail.

A little of the pathological terminology used is unfamiliar to the British reader. The principal example, which forms part of Fig. 92—a table reproduced from a publication by other authors—is the puzzling comment on the management of patients with multinodular breast lesions: "Mastectomy advisable if proliferative mastopathy is suspected".

There are 123 references and a serviceable index. This book provides a critical and balanced survey of the present place of aspiration cytology in breast disease.

G. A. K. MISSEN,
Consultant, Dept. Clinical Microscopy.

"Cash's Textbook of Physiotherapy in Some Surgical Conditions". 6th Edition, edited by P. A. Downie. Pp. 344. Price £5.25. Published by Faber.

This is the updated version of one of the two original physiotherapy text books that Miss Cash produced in the 50's and which have enjoyed well merited success among students and staff ever since. Regular readers will know that Miss Downie has taken editorial responsibility for this pair and their "spun-off" companion volumes and that she is presiding over a re-writing process which has already brought us some welcome revisions.

A new, and appropriate, inclusion in this book is a short but highly instructive chapter on using medical libraries, which is particularly to be commended to third-year students preparing for their Part II examination but which will also help those of us who were brought up on a couple of antedeluvian text books and a random opinionated collection of notes derived from our teachers.

The book, overall, strikes me as uneven in quality, with parts of it very good—including a typically rumbustious chapter from Sandy McLaren which gives a very good idea of what its author represents—and others rather perfunctory and with a dated air. I would guess that as time goes on the fissiparous tendency which has given birth to the Chest and Neurology books will lead to further more circumscribed but more detailed extra volumes, and that the "Medical" and "Surgical" Cash books will disappear. The field of physiotherapy has, since the 50's, narrowed down but the depth of knowledge required has increased to an even greater extent, and there is little place now for the superficial treatment of a wide range of topics.

Despite that, this latest book is an encouraging sign of a continuing evolutionary process which will be recognised in physiotherapy Schools and departments in this country and abroad, and which should be drawn to the attention of other medical and paramedical disciplines.

R. J. COOPER,
Principal, Dept. of Physiotherapy.

"Medical Microbiology", by C. G. A. Thomas. Pp. 406. Price £4.25. Published by Balliere Tindall.

I am always put off reviewing books when chapters begin with a well known phrase or saying by an eminent writer, philosopher, or scientist—who am I to criticise a book by an author who is so widely read? In this case little criticism can be levied except to say that there are a number of books aimed at students studying medical microbiology and this is one of the better ones.

The first half of the book is devoted to general properties of bacteria and viruses (useful for the Introductory Pathology in the Basic Medical Sciences course), transmission of micro-organisms, with a chapter on the control of hospital infections. This latter chapter not only deals with common agents involved in cross-infection but also food poisoning organisms—a sound idea since a high percentage of food poisoning cases arise in hospitals. Further chapters include ones on chemotherapy and host immune responses. I felt that four chapters on aspects of the immune response was too long winded, especially as there are a number of very good recent texts on the immune response written by immunologists. The second half of the book deals with specific groups of micro-organisms and diseases they cause. One welcome innovation is a short chapter on Helminths ("worms") not often found in microbiological books and omitted from many lecture courses. In fact all the chapters are short but most of the information needed by medical students is present and in an easily accessible form.

This, the 4th edition, is up to date with changes in disease patterns and new aetiological agents and is a very readable book.

D. McCANCE,
Dept. of Microbiology.

Correspondence

Missing Table

Sirs,

During the weekend of June 16th/17th a small wooden portable table was found to be missing from the corridor of the 12th Floor of the Tower.

This table is of great historical value as it is an example of one of the early operating tables for children. It has no other value whatsoever and I should be most grateful if anyone finding this table would contact my secretary immediately (extension 2702).

This table is part of a historical collection of the Evelina Children's Department and is hopefully going to be on view shortly.

Please help in any way you can.

Dr. MICHAEL JOSEPH,

Consultant Paediatrician,
Guy's Hospital, SE1 9RT.

Sir Arthur Hurst

Sirs,

Sir Arthur Hurst, as a charismatic figure, was second only to Sir William Arbuthnot Lane, who dominated the surgical thinking at Guy's Hospital up to the time of his retirement in 1919, and who was at the height of his activity and fame when Hurst was appointed to the staff in 1907.

Dr. William Mann's appreciation of Sir Arthur Hurst in the *Guy's Hospital Gazette* of June 1979 recalled to me vivid memories of this remarkable physician. As times goes on, fewer of his students will be able to tell of their reminiscences of Hurst, and the *Gazette* should invite them to do so now. I am sure that it would be of interest to record for present and future generations of Guy's students the impressions made by Hurst on his disciples, even, as in my own instance, to record a worm's eye view of the great man.

I was clerk on Hurst's firm in 1920, this being my second clinical appointment. My first one had been as a surgical ward clerk. Hurst made a striking impact on the impressionable young man. He gave the appearance of considerable energy, coiled up like a spring, restless, with abrupt movements and urgent demands for information on the patients. He spoke rapidly in short staccato sentences, interrupting the flow of speech only when forced to take a breath (he was an asthmatic). His eyes, with their hooded lids, were compelling, grey-green, with a depth of clarity and directness of gaze that I have noted in few other men. I can well understand his success as a hypnotist. He radiated authority. Unforgettable to me is one ward round when Hurst swiftly examined a patient, a man of over forty who had been paralysed and bed-ridden for a number of years. Hurst told us that the man had an hysterical paralysis and detailed two of us to re-educate the man to walk. We each took one arm and supported the patient up and down the ward, and at the end of half an hour he was able to make his own faltering steps. Of course, this was a miracle, and what Hurst said after that was unquestioned.

It was only later that one began to doubt such dicta as *"Patients with asthma do not die of the disease"*, and *"Patients with gastric ulcers on treatment in the ward with the Sippy diet do not perforate nor suffer gastric haemorrhage."*

One of Hurst's most outstanding contributions was his insistence on the importance of the use of X-rays in the study of oesophageal and gastrointestinal diseases, and he was a pioneer in this field. He expected his registrars to conduct X-ray screening and follow-through of barium meals, and the other medical registrars followed suit. The X-ray equipment in my day consisted of a gas filled tube and a fluorescent screen. There was no image intensifier, and we were not allowed to take photographs. In my instance, instruction was given as to an apprentice by the then Medical Radiologist, the late Dr. Lindsay Locke, who, though not very communicative, was a most delightful gentleman. I am not sure whether it was desirable that registrars should have been responsible for this type of examination, but from the practical point of view it was an advantage, there being only the one medical radiologist on the staff.

Hurst's house physicians and registrars were enjoined to become experienced and proficient in the use of the proctoscope and the sigmoidoscope. This

direct visualisation of disease structure was, of course, a significant advance at the time in the diagnosis and control of treatment: these examinations were carried out without an anaesthetic, in contrast to what was then customary on the surgical wards, and thus they could be repeated readily and safely.

By 1920, Lane had left the Hospital, and no one went to the length of colectomy for so-called "intestinal toxaemia", but the idea that toxic products were absorbed from the colon was still propagated by one physician on the staff, and no doubt it was accepted in the then current medical thinking. It was regarded as essential, therefore, that the bowels be regularly opened, and the colonic wash out parlours flourished. Hurst was an investigator and would have none of it. I remember, correctly, I hope, that he filled the rectum of one of his assistants with cotton wool which was left for a week, and in the subsequent discussion Hurst said that apart from a certain amount of discomfort, there were no ill effects. Maybe this investigation has been reported in Hurst's publications.

My memory of the "combined rounds", on Friday afternoons, held on Mary Ward, is of a large concourse of students, house officers, visiting physicians, and sometimes Charles Symonds and John Ryle, with the elegant frock-coated Sir Adolphe Abrahams, dominated by the taut figure of Hurst, watching the speaker intently, hearing aid at the ready. The latter was conspicuously turned off with a click, as Dr. Mann says, when Hurst thought that the speaker was of no interest to him. Many visiting physicians came regularly, for Hurst's genius was a potent attraction.

I agree with Dr. Mann, that Hurst indicated very strongly what the surgeons should do to his patients, and he chose specifically who was and who was not to operate.

There were three other contemporary physicians at Guy's with whom I came into contact as house physician or medical registrar. They were Herbert French, John Fawcett and Arthur Beddard, whom students of my generation remember with affection, gratitude and respect. All three differed greatly in personality and all three were larger than life, but Hurst was undoubtedly the most dominant and exciting figure at the time. His teachings influenced the whole of the medical side of the Hospital.

I hope, Dr. Mann will, at some time, give us a complete record of Hurst's numerous writings, including those published in the *Guy's Hospital Reports*, of which Hurst was editor from 1921 to 1939. By far the greatest number of papers in the *Reports* were by Hurst himself and his associates. During his editorship, the *Reports* attained a world wide reputation.

During a recent B.B.C. discussion on graffiti, one example quoted was, "*Nostalgia ain't what it used to be*". By that, I assume, the writer meant that he was no longer moved by his recollections of the people with whom he had been associated in early life. I am glad to say that Dr. Mann's article awakened in me a deep response of affection and gratitude towards Hurst and my medical teachers of over fifty years ago.

LOUIS FORMAN

22 Harley House,
Marylebone Road,
London, NW1 5HE

re: Mr. Arthur Stocker
On Logical Positivism

Sirs,

The word "All" in the proposition, *All unmarried men are bachelors,* draws attention to the fact that it is governed by the universal as opposed to the existential quantifier. This, quite simply, is a requirement of symbolic logic.

Yours faithfully,

JOHN PINI

c/o Gazette Office,
Mary Sheridan House,
London SE1 9RT

Sport

This month sees articles from our glorious (in small parts) Summer past. The reason for their late inclusion into these hallowed pages is not due to the tardiness of my excellent correspondents in presenting their copy (Charlie's article arrived at the eleventh hour again but was there nonetheless). It is due in fact to the reluctance of the irksome editors, once again in their bearded belligerent mood, to grant the Sports Section the pages it deserves. Why they should wish to suppress the great deeds of Guy's men, men bringing glory and honour to this sacred establishment is beyond my comprehension. I warn you, Ade and Phil, tamper with these pages at your peril!

The articles reminding us of the sultry days of Summer include a Cross Channel Crossing by the Sailing Club for the Glory of Guy's (and the finances of the Club and R.N.L.I.). Charlie Tunnadine writes of the Bognor cricket tour in his usual inimitable style (although in places he seemed to be exploring the literary possibilities of the comma).

Hearty congratulations to the Tennis Team under Andy Morgan for winning the U.H. Cup—well done boys after a long hard (and controversial) season.

However, not all is of warmer days—the Rugby Club report early season fixtures and show encouraging (and some slightly discouraging) results. Concerning the Rugby Club, Brian Keevil informed me that he didn't appreciate being made a pin up—sorry Brian, could I have my head back please?

At the time of writing the rest of the Winter sports have only just begun and reports are not yet available—watch this space!

G. D. C.

GUY'S HOSPITAL CROSS CHANNEL SAIL

Dover to Boulogne, Friday, 13th July, 1979

Richard Thomas first put forward the idea of a Sponsored Sail to raise money for the Royal National Lifeboat Institution (and Guy's Sailing Club!). Many people were keen to participate in what they thought would be a weekend of sailing by day and drinking by night: when they heard that the sail was from Dover to Boulogne and back most people suggested that a visit to the York Clinic was called for.

Two weekends were suggested for the attempt—one being the 25th of May and the other being 13th July.

Considerable effort was put into collecting sponsor money. Many afternoons were wasted trying to gain sponsorship from businesses in the City and some other large companies.

Four dinghies (two Fireballs, a 505 and an Aquacat) arrived at a camp site in Dover in the early hours of May 25th after a day of panic. Three of the four boats had to have new masts, the last mast arriving at 3 o'clock on the 24th!

At 5 a.m. on the 25th the boat crews were awoken by Pete Woodhead's car spluttering into the camp site, followed closely by Andrew Girling and Gary Manning who were still warm from the Rugby Club dinner and wearing their own style of sailing clothing: dinner jackets.

The boats were in the water at 8 a.m. and we left Dover at 9 a.m. The big seas and force 4 winds outside the harbour showed signs of imminent deterioration so the attempt was postponed. The wind increased to force 7 for the rest of the weekend, forcing James Rankin to leave the support (rescue) vessel in the inner harbour for the week.

The boats met again in Dover on Friday, 13th July (!), Gary Manning arriving with his Aquacat which looked like a converted bed. Andy Houghton and Richard Loveless were with the Jollyboat and Richard Thomas and Jon Brewin in the 505. Rob Heard did not make it and was apparently in Dorset looking for his boat. James Rankin, William van't Hoff, Liam Broughton and Rob Weighell arrived at 4 a.m. after a frantic sail back from Cherbourg in the Carter 33.

The boats left Dover at 12 in force 3 winds after clearance had been given by Dover Harbour Police. Thanks to them for keeping the hovercraft and ships away from us.

The wind direction enabled us to set a close reach course to the Varne lightship, which was passed at 13.30. The intrepid dinghy sailors were now in the middle of the busiest shipping lane in the world. Gary Manning was seen relieving the incredible tension he was

Right: Richard Thomas' '505', flying the burgee of the Boulogne Sailing Club.

Below: the "fleet", as seen from the yacht, "Toute Seule".

under by throwing peanuts to the other crews.

The North-east shipping lane on the French coast was cleared at 14.00. The wind died and the boats were swept towards Calais by the 3.5 knot tide. At 18.00 the wind filled from the South-West and a fast passage was made up to Boulogne with the boats sailing at 7 miles/hr., arriving at 21.00.

The Boulogne Sailing Club Secretary gave us a good welcome and arranged for us to stay on stretchers in the Boulogne life-boat station: Societé Humaine et des Naufrages.

Another 6 a.m. start to hear the weather forecast. Departure time was supposed to have been 12.00 to catch the favourable tide but a French diving school vessel rammed the Rankin's yacht in the Marina removing the bow safety rails and damaging the deck.

We finally left at 16.20. The Aquacat was towed to ensure that we arrived in Dover before dark. A fast return trip took only $4\frac{1}{2}$ hours. The Normandy P. & O. and Sealink ferries passed within half-a-mile of us on the way.

The Dover Yacht Club gave us a very warm and liquid welcome, the day ending with four of the crew asleep in a curry house. We were saved by the Kent Sailing School who allowed us to sleep on the floor of their bar.

Thanks must go to James Rankin, Rob Cook and Will van't Hoff for the hours spent getting the support vessel to and from Dover, for continuous liaison with the coastguards and for finding Boulogne! Thanks to our sponsor form collectors (now adept collectors!), to the Commodores especially Mr. Kinder for encouragement and support, to the members of Dover Y.C. and to the Department of Trade who control the Channel (they have not complained).

We are very grateful to Patrick Marc, the small Frenchman who arranged accommodation, food and vino in Boulogne. Finally we thank Dover Coastguard for giving us permission to cross the Shipping Lanes and for broadcasting our position, speed and track at regular intervals (it certainly helped the navigation!).

Next year: sail to Norway.

Richard Thomas,
Captain of Sailing Club.

Would any sponsor who has not yet been able to donate please send their contribution to: R. Thomas, Prosthetic Laboratory (Floor 20), Dental Tower, Guy's Hospital, London, SE1 9RT.

"Homeward bound"

CRICKET

Sussex Tour

As ever, the tour turned out to be the highlight of the cricketing year, even if the results don't seem to entirely bear this out. In fact, we were the better side in all our games, but the generous spirit in which they were played tended to give the side batting second a considerable advantage (we batted first in all three "proper" matches).

It's difficult to state freely all the goings-on of the tour, partly because many of them will mean little to those who weren't present, and partly because I don't want to get anybody arrested. However, since I believe a rival version to my copy is being furnished by the team proboscis, a fairly complete picture may yet be obtained.

Our first game was against Bognor C.C. on Sunday, 5th August, at 2 p.m. To ensure a relaxed start, the captain arranged for everybody to meet in the East Wing at 10. This they all did except the aforementioned dunce, who, being sh****d out from yesterday's Knebworth concert, didn't wake until 11.30. Fortunately the team didn't notice his absence, and left without him. However, due to some careful driving, the full team assembled but five minutes late, the toss was won and the game was on.

We were given a good start, thanks to some dashingly aggressive (though invariably cool) strokes from our man of style and chic, James Smith (long body, short legs), and some extraordinarily late cuts by the portly pensioner with the prominent proboscal protuberance and pearly pate, Peter Joliffe. James was replaced by *Mike Glover,* who, it should be noted, had not yet scored a century this year (possibly due to his one man survey into the long-term effects of the imbibation of the fermentation products of grape and grain). He would not have done today, either, had not a technical decision gone his way, when he was caught on 11. The appeal was rejected, since although the ball was in the unfortunate mid-off's hand, said hand was no longer attached to the fielder's arm, such was the power behind our man's lusty blow. The day belonged to *Glover,* in spite of useful contributions from Joliffe (28) and Tunnadine (me) (21). His final tally was 146, a brutally (and beautifully) violent innings including 11 sixes (nine of which were over the fence at one end, keeping one lad busy most of the afternoon), and two lost balls. I declared at roughly half-time with 237 for 6, and a rather dazed Bognor side prepared themselves for their reply.

The opposition innings was characterised by some very bad fielding and even worse umpiring. We started well, wih some particularly fine bowling from Paul Shepherd. He dismissed one opener with a well-taken slip-catch by *Mike Glover,* while Tunnadine got rid of his replacement at the other end. In the next over Paul and *Mike* had their other opener removed in identical fashion, only for the umpires to give him not out—one who genuinely couldn't see the catch, the other not looking, while the batsman did not walk. Tut! Tut! If this was the Gentlemen v. the Players, we know who was which, don't we? This chap went on to make 70-ish, and in spite of a good catch from Peg-Leg, we lost in the second last over, other reasonable chances having not been accepted. (This was not helped by the refusal of a brilliant run out by Liam B. and *Mike G.*, where the batsman was stranded by 2 feet.)

Any misgivings, however, were soon washed away, and a good time was had by all, I'm told. Unfortunately, I had to go back to London that night. I got as far as 400 yards outside Bognor before running out of petrol, and so rejoined those of the party who were staying on. The order of the day was Curry x 8, P. J. obviously having lost all pain sensation in his mouth years ago—signs of a misspent middle-age. The next problem, apart from *Glover* trying to make the boarding house open-plan by removing the doors, was fitting eight people into seven beds. Peter and Mick Corlett gazed fondly into each other's eyes, immediately volunteered to share a double bed and wandered off into the sunset.

Next morning I beat a hasty retreat to London, and so news of that day, the game against Radlett (skippered by Ted Dexter's brother, Mike), the evening to follow and Tuesday morning, I leave to Old Father Time (who, I'm told, when he once asked the way to Bermondsey Market, was told to follow his nose, and ended up in Inverness).

I rejoined the team on Tuesday for our game against Brighton Hospitals, at Bevendene, possibly the smallest pitch this side of Lilliput. It was a thoroughly miserable day, cold and drizzly, but, well, we're Guy's Men, dammit, and since there was neither bar nor Space Invaders, we got on with it, starting at 3 o'clock. A remarkably good start, with an inspired change of batting order (I've

got to get in on the act somehow), saw the advent of a "star bowler" as "a" star "batsman". "A"lex "W"illiams, came of age (13, I believe), and supported by a useful 32 from Jolly, went on to make a confident 58. *Glover*, not to be outdone, with *his* new-found confidence, and looking like an alcoholic grizzly bear who'd been woken from hibernation in mid-January, got his second ton of the tour, even though from the evidence of the first three balls (any one of which should have bowled him), he couldn't actually see. 205 for 4.

The fielding of our side that day had to be seen to be believed. Fortunately it couldn't be, as it was as dark as midnight in a crypt. That's our excuse, anyway. The bowling was awful (mine was, at least), though Alex was economical, and Paul Shepherd just unlucky. Alasdair Jacks trundled along nicely, with consistent length and line (all of them half-volleys just outside off-stump). But it wasn't a pitch for bowlers. There were two beautiful catches, however. One dropped by Paul, the other dropped by Alasdair. I missed a shy at the wicket from 15 yards by about 10 yards, for four overthrows; and *Mike Glover* was eventually substituted by a considerably more athletic Foster Bros. window dummy. Simon Moore was very energetic and saved almost as many runs as most other people threw away, but was severely hampered by playing in bare feet, resembling at times Bambi on ice. It was still a close game, however, and they reached our total on the third last ball of the day.

We then high-tailed it to the Staff Bar in Brighton where hospitality was extremely warm and generous. At some stage during the evening, I stupidly let slip that it was my birthday (for your diaries: 7th AUGUST), and Liam Broughton's hospitality became even warmer, proffering me some ridiculous concoction. I remember little else, so Peter will have to oblige with other details. He may, however have forgotten talking, with Liam, to two of the ugliest ladies seen outside London Zoo, so I'll mention it for him, so he won't lose his fondest memory. Also it was nice to see one or two old faces, such as Chris MacLaughlin and John MacArthur. (The door's the thing with the handle, John.)

Next morning was a little uncomfortable.

We indulged ourselves in the pleasures of the Bognor seafront, Mick James T. Kirk Corlett revealing his prowess to the world. He's good at Space Invaders, too. Much milk was consumed, as we travelled to Middleton for our final (and, we expected, our most difficult) game of the tour. First there was much haggling over who owed what to our landlady, who had tolerated us after our first night, thanks only to our diplomatic envoy to Liverpool, Jerry Ryan. When we arrived, we had eight men, so it was fortunate that I won the toss again, thus enabling us to bat first. We did not start brilliantly, and when *Mike Glover* was out for 17, forcing me out from my 17th visit that morning (to powder my nose), onto the pitch, a collapse seemed imminent. However, lacking the strength to lift my head, I managed to stay in, and when joined by Alasdair Jacks in electric flat-batting form, we put on 140 in about an hour and a half. I was out for 75, while Alasdair finished with an excellent undefeated 85, giving 222 for 5 dec.

This was a generous declaration on a perfect batting pitch, and we were disappointed when, having removed one opener for three runs, Middleton managed only five more runs in the next 40 minutes. Fortunately, when their next batsman was out, the number 4 had no defensive intentions. He scored a thrilling 61 in about 30 minutes before being caught, by Tunnadine, off *Mike Glover* on the boundary.

They were now just back in the game, and their captain continued the aggression with a couple of lovely straight sixes before being out. However, it seems we were just too good. Paul Shepherd bowled superbly, as did Alasdair, on such a dead pitch, Alex was accurate as always, and *Mike Glover* very astute in his spell, taking three wickets. Unfortunately, we just ran out of time, though had a sharp chance been taken at gully in the last over, we may just have scraped a deserved win. As it was they finished on 128 for 8, morally, if not actually, thrashed.

Celebrations continued in the clubhouse for quite a while until eventually people began to filter away back to the humdrum of London or Liverpool. It was a most excellent few days, with a surprisingly high standard of cricket. I apologise to those people who didn't get to bat or bowl, and thank everyone concerned for making it so enjoyable, particularly Simon Perkins for coming so far, Jerry Ryan and Simon Moore ditto, and Liam Broughton for being such an idiot.

To anybody who has little money and wants a great few days in Bognor next summer—keep early August free.

NETS

Just a repeat of last month's message:

We are trying to organise indoor nets sessions at Lord's next spring. This is for your benefit only—not a selection procedure, and are immensely useful and enjoyable. A small charge is made, but this is nominal at most. So, if you could let me know, via the pigeon holes (either mine, or the Cricket Club's), if you are interested, and roughly how often you would like to go, please do so as soon as possible.

AGM

The Cricket Club AGM will be held on November 8th, at 5.30 p.m. in the Senior Common Room (directly above the accommodation office). This will involve election of new officers, and a chance to make any suggestions or recommendations about the club. I hope as many of you as possible will come.

Charlie Tunnadine.

MEN'S TENNIS

Here's the news you've all been waiting for with bated breath. The Guy's team has done the Double. Having won the Inter-Hospitals League earlier in the season, we have now walked off with the Challenge Cup too. A remarkable achievement, one could say, but I won't.

The six men from Guy's took on the might of the London Hospital in a Final held early in October—ridiculously late in the year you might say, and I would wholeheartedly agree with you.

Our team arrived half-an-hour early in an attempt to impress the opposition by being warm and on form at the start of the match. One hour later, we were cold and wind-swept and suspicious glances which said, "Have you got the right day?", started to flash my way. However, arrive they did, albeit late, and the tennis soon began in earnest; but not before the gates to the ground had to be closed because the crowd of supporters was reaching the point where more than the fingers of one hand would be needed to count them.

In the first round of matches, Guy's unexpectedly went 3—0 up with by far the best tennis being played by Rich Wellington and Rick Plowman, who defeated the opposing first pair in a very close and high standard match. The three supporters clapped heartily and the buzz of excitement could be felt all round H.O.P.

Unfortunately, the prospect of victory seemed to go to everyone's heads because in the second round we promptly lost two of the three matches. The majority of the supporters now retired looking distinctly cyanosed leaving the forlorn figure of Lloyd Denmark, who did up the top button of his jacket and continued to survey the scene with a critical eye.

In the final round, however, racket again began to hit ball over rather than into the net with the result that we won two of the three remaining matches, thus winning the Final 6—3 overall.

Tim Thurston, Simon Moore (in his now-famous shorts) and Jonathan Pringle also played extremely well to enable Guy's to take its second tennis trophy of the year. When was the last time that this was achieved?—answer please on a postcard to . . .

Andy Morgan.

RUGBY

Guy's 7 pts., Askeans' nil
Honor Oak Park, 22.9.79

Askeans' have regularly proved a bogey side for Guy's over recent seasons and in their centenary year must have been hoping for a good showing. Instead they met a Guy's pack in top form with aggressive driving play from the back row and very solid in the tight, with the shove upsetting the Askeans' eight.

Guy's found great difficulty in converting the territorial advantage into points, however, with the Askeans' defence reinforced by half their pack as they played a three man scrum for much of the second half. Guy's scores consisted of a penalty goal by Underwood and a late try in the corner by Armstrong who unfortunately is not available for Guy's for the rest of the season.

The Guy's midfield attack definitely lacked punch without Reece in the centre but if the pack continue to play as well as this it could be one of the better seasons for Guy's.

Team: Poppelwell, Rose, Neill, Beard, Keevil, Brazier, Armstrong, Williams, Kingdon, Williams, Jennings, Bryant, Cox, Underwood, Portelly.

Other Results:

Guy's 10 pts., Beckenham 23 pts. 29.9.79, H.O.P.

Guy's 6 pts., Bromley 10 pts. 15.9.79, H.O.P.

Guy's 3 pts., Cheltenham 52 pts. 1.9.79, Cheltenham.

Guy's 16 pts., U.S. Portsmouth 27 pts. 6.10.79, Burnaby Road

The Services side have had their best season for several years with big wins against several sides (including 74 points against St. Mary's), so Guy's visited Portsmouth with some trepidation, and kicked-off with the advantage of a strong following breeze.

The first quarter was all Guy's, with the pack playing well together and forcing two penalties which Moore converted. Then Portsmouth were allowed to fight their way back due to silly mistakes by Guy's leading to penalties for offside—which the Services' kicker took to good advantage. Guy's turned 9—6 up through another penalty by Moore.

With the wind the Services put on the pressure but could only score one try and most of their points haul came from penalty kicks which the enthusiastic Guy's pack gave away regularly. Moore added another penalty and Beard scored a try in the dying minutes after a splendid break by Girling on the right wing.

A good performance, especially up front against an experienced outfit but we will have to cut out those silly penalties.

Team: Poppelwell, Rose, Neill, Beard, Keevil, Brazier, Williams, King, Kingdon, Williams, Jennings, Cox, Maggs, Girling, Moore.

Guy's 9 pts.,
Cambridge University 55 pts.
Grange Road, 13.10.79

Guy's faced a strong University XI just back from a highly successful tour of Japan. With the Guy's pack so strong these days it was essential to deny the swift Cambridge backs good possession but with new recruit from Rosslyn Park, Ackford, dominating the line-outs for Cambridge this was virtually impossible.

Guy's were four tries down in the first 20 minutes in a period when the Cambridge backs could do nothing wrong with Rose the Cambridge fly-half controlling the match and converting all the trys. Turning 25 points down Guy's had spells in the second half when their driving loose play got Cambridge on the defensive but with good possession Cambridge got four trys in quick succession, all once again converted by Rose. The only reply Guy's could make were a penalty goal by Hackett and a try by Poppelwell from a short penalty.

A disappointing result since the Guy's defence which had looked so good against U.S. Portsmouth the previous week was cut to ribbons by the talented University backs while the Guy's forwards never got better than 50 per cent ball which is just not enough in this game.

Team: Poppelwell, Gibson, Neill, Beard, Keevil, Brazier, King, Williams (L.), Kingdon, Hackett, Jennings, Cox, Maggs, Williams (H.), Moore.

Gareth Parry.

LADIES' WATER POLO

On Sunday, 14th October, the Ladies' Water Polo team went to Canvey Island. Our opponents were the Runnymede Water Polo Club who play at the Waterside Sports Centre, where we arrived for an 8 p.m. start. We began the game against their "A" team, who were very much better than we were. When after the first quarter the score was 7—0 to them it was decided that we should play the "B" team instead. We were then more evenly matched. They managed to score a further four goals; for Guy's Mary Ganczakowski scored two and Elizabeth Palmer one.

Despite our rather poor start against their experienced "A" team, Guy's were playing very well towards the end. Three of our players were Freshers and had never played water polo before yet they were soon playing very competently and need to be congratulated. We were missing some of our better players and goalkeeper, so all in all we felt we had done quite well. Helen Kinsella played very well in goal against their "B" team.

Finally we must thank Dave Rickard, the men's captain, who came along to instruct us in game tactics and support our team.

Team: Mary Ganczakowski (Captain), Elizabeth Palmer, Sally Brown, Helen Kinsella, Sian Davies, Julie Hume-Kendle, Angela Weekes.

M. G.

Hospital Information

PAPERS BY GUY'S MEN

Adinolfi, M. "The permeability of the blood-CSF barrier during foetal life in man and rat and the effect of brain antibodies on the development of the CNS." **Protein Transmission through Living Membranes,** Biomedical Press, 1979, pp. 349–364.

Amiel, G. J. Pre-eclampsia, **Update,** 1978, **16,** 1183.

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Amlot, P. L. *and* Adinolfi, M. (1978). Serum β_2 microglobulin and its prognostic value in lymphomas. **European Journal of Cancer,** 15, 791–796.

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Reitamo, S., Klockars, M., Adinolfi, M. *and* Osserman, E. F. (1978). Human Lysozyme. **La Ricerca, 8,** 211.

Stewart, I. McD. G. Relation of reduction in pressure to first myocardial infarction in patients receiving treatment for severe hypertension. **Lancet,** 1979, April 21.

Due to Internal Mail difficulties the full list of 'Papers' will appear next month

NEW STUDENTS 1979

DENTAL SCHOOL

Mr. S. G. Ambridge, Nottingham High.
Miss A. Barton, Lancaster Girls Grammar
Mr. A. M. Bookey, Carmel College, Wallingford
Miss F. C. M. Bradshaw, North Gwent College
Miss S. F. Bridger, Chelmsford County High, Chelmsford College
Miss S. K. Brown, Abbey School, Reading
Miss A. D. Burgess, Ursuline Convent, Brentwood
Miss P. Buttoo, Parrs Wood High, Manchester
Miss S. J. Campbell, Rickmansworth School
Miss T. F. Cautley, Bishop Foxes Girls Grammar, Taunton
Miss S. J. Chapman, Guildford High School
Mr. C. Clamp, St. Joseph Williamson's Mathematical School, Rochester
Miss M. L. Colgan, Larkhill High School, Preston
Mr. A. T. Currie, Wakeman School, Shrewsbury
Miss A. S. Davies, Bromley High School
Mr. P. Desbruislais, Robert Smyth School, Market Harborough
Mr. C. M. Dickinson, Rusking County High, Crewe
Miss L. C. Doyle, Brigidine Convent, Windsor
Miss M. B. Edney, Burford School
Miss J. A. Evans, Pates Grammar For Girls, Cheltenham
Miss H. Faux, Woodhouse School, North Finchley
Miss C. Fitzgerald, Penketh High
Mr. D. W. Geering, Priory School, Lewes
Mr. A. J. Gibbons, Maidstone Grammar
Mr. R. P. Goddard, Bedford School
Mr. N. J. Gray, Farnborough 6th Form College
Mr. P. G. Haggqvist, Sir William Borlase's School, Marlow
Mr. J. S. T. Hamilton, Royal Grammar, Lancaster
Mr. T. R. Harker, Ernest Bailey Grammar, Matlock
Mr. W. J. A. Harty, St. Benedicts, Ealing
Miss A. M. Helgeson, Wyggeston Collegiate, Leicester
Mr. P. S. Henderson, Royal Hospital School, Ipswich
Miss J. C. Howden, Roedean School, Brighton
Miss R. T. Hubert, St. Joseph's Convent, Abbey Wood
Mr. R. D. W. Hughes, Dyffryn Comprehensive Purbook Park School
Mr. R. J. Hurrell, Old Swinford Hospital School, Stourbridge
Miss J. Huxley-Duggan, Newstead Wood School, Orpington
Mr. B. W. Irving, Eggars School, Alton
Mr. K. V. Jacques, Newport Comprehensive
Mr. A. G. Jones, Dynevor Senior Comprehensive, Swansea
Mr. S. T. Kakkad, Kingsway Princeton College
Miss R. Kean, Ursuline Convent, SW20
Miss A. C. Kenward, Tunbridge Grammar School for Girls
Miss J. A. Keska, Croydon High for Girls
Mr. C. J. R. King, Haslebury School, Hertford
Mr. G. J. Lauer, Hasmonenan Boys School, NW4
Miss J. E. Legg, Chelmer Valley High, Chelmsford College
Mr. R. W. K. Li (Overseas), Sevenoakes School
Miss R. F. A. Longfield, Croham Hurst School, Croydon
Mr. J. K.-C. Ma, Latymer Upper, W6
Mr. D. P. McGuckin, Douai School, Reading
Mr. I. P. F. McLean, Downside School, Bath, Ludlow College
Mr. M. J. McMurdo, Kent St. Senior High, Perth, Australia, Kingston College
Mr. I. G. Needleman, Mill Hill School, Davies
Miss C. S. Nix, Cheltenham Ladies College
Miss E. K. Norland, James Allens Girls, SE22
Mr. R. E. Norris, Hurstpierpoint College
Miss A. J. L. Oates, West Kirby Grammar
Miss S. M. O'Brien, Bellerive Convent, Liverpool
Miss C. M. D. Osborn-Smith, Henrietta, Barnet, NW11
Mr. A. G. Owen, Brentwood School
Miss J. E. Owen, Ysgol Sir Hugh Owen, Caernarfon
Miss F. Padhani, St. Anns Convent, W5, Acton Technical College
Miss R. M. Park, Birkenhead High School
Mr. D. G. Parr, Dr. Challoners, Amersham
Miss K. Patel, Hendon School, Hendon College
Mr. P. N. Poole, Bishop Gore Senior Comprehensive, Swansea
Miss N. Price, Ystrad Mynach, Hengeod
Mr. N. H. R. Pryke, Sevenoakes School, Davies
Miss V. J. Reese, Cheltenham Ladies College
Miss P. A. Riscley-Prichard, Dauntseys School, Devizes
Mr. C. V. S. Sams, Chichester College, University of Surrey
Mr. R. C. Scott, Cranbrook School
Mr. C. R. Selmon, Downside School
Mr. J. D. Shepherdson, Hitchin Boys School, North Herts Technical
Miss J. Singleton, Tonbridge Grammar for Girls
Miss T. M. Y. Tong, Rosa Bassett School, SE27, South London College
Miss S. L. Tuck, Tonbridge Grammar for Girls

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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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Passim

It was a pleasure to see so large and so well-informed an audience attending the recent Extraordinary General Meeting of the Clubs' Union. This meeting was called to debate the Corrie Bill, and a decision was made at the meeting to allow a group of students representing Guy's Hospital Clubs' Union, to attend a march against the Corrie Bill.

The main significance to life at Guy's itself, is not the content of the E.G.M., however important it may be to the country as a whole, but that the meeting took place at all. The cavillous might maintain that the calling of an E.G.M. is not a difficult procedure, as only thirty members' signatures are required—but such a move is far from usual, and indicates an increased awareness and motivation on the part of Guy's students, and can be taken as an indication of the glorious correctitude of the present constitution. Or can it?

It is undeniable that the E.G.M. was a considerable success. Massively quorate, it showed a fine sensibility for intelligent and orderly debate—but this does not mean that the Clubs' Union will now be able to ride off into the perpetual sunlight of ever-quorate Union General Meetings. One only has to contemplate the dismal turn-out at the Summer U.G.M. to realise this—and Guy's students (of all people) are hardly likely to have become suffused with interest in Clubs' Union affairs with such rapidity. The success of this E.G.M. rests on other factors: the unusual interest of the topic in question; the lack of tedious routine business which so clogs and stultifies a U.G.M.; and the fortuitous timing, so early in the Christmas term—when Freshers are still fresh, and the others less jaded.

Under the present constitution, the U.G.M. is the policy-making body of the Clubs' Union. If it is inquorate, it cannot delineate policy—as is indicated by the presence in the agenda for the Christmas term U.G.M., of such hoary ancients as the inclusion of the Catholic Society as a Constituent club (at least the third attempt for a quorate vote), and of that perennial favourite, the Contraceptive machine for Boland House (could it really have started in Summer of '77?) That such lack of decision can exist for so long indicates a basic flaw in the present structure, and it is pleasing to see in Clubs' Union News that the present Clubs' Union Council recognises that such a deficiency exists, and has set up a constitutional sub-committee to look into the matter. Two members of this committee are preparing a "discussion document" as the basis for a new constitution, and one expects that the final proposals will be both effective and democratic—and that they will finally curtail the debilitating, tedious and often fatuous discussions about the constitution which have been so prevalent in the last decade.

It is greatly to be hoped that the Clubs' Union can start the 1980's with renewed confidence based on a firm, workable, democratic constitution, and from this basis continue to extend a sane influence within the hospital, within British medical students' associations, and within the medical world as a whole—a wish, one feels, that will be shared and facilitated by most of our readers, almost all of whom are Life or Honorary members of this same Clubs' Union.

News in Brief

Robechi International Prize

Our heartiest congratulations to Dr. Gabriel S. Panayi, M.D., M.R.C.P., Senior Lecturer in Rheumatology in the Department of Medicine, and Honorary Consultant Rheumatologist, who has been awarded the third Robechi International Prize.

The prize, awarded every four years for research in Rheumatology, was presented to Dr. Panayi at the IX Congress of the European League against Rheumatism, which was held at Wiesbaden last month.

Dr. Wallace Fox

The University of London has conferred the title of Professor of Community Therapeutics at the Cardiothoracic Institute on Dr. Wallace Fox. Dr. Fox (Guy's 1943) is the Director of the M.R.C. Tuberculosis and Chest Diseases Unit at the Brompton Hospital.

Guy's Hospital Gazette

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: 2nd December, 1979 and 13th January 1980.

Copy may be sent to us at Mary Sheridan House, Guy's Hospital, SE1 9RT.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (prepaid, minimum £2.00).

Non-subscribers are charged £2.00 (prepaid) for all notices other than Death.

Degree in Radiation Protection

Our compliments to Mr. B. W. Beeching, B.D.S., M.Sc., who has been awarded an M.Phil (London) in Radiation Protection in the Faculty of Medicine.

Student Medical Education Committee

The following were elected as representatives on the Student Medical Education Committee:

Clinical Representatives	Preclinical Representatives	Staff Representatives
L. Denmark	Miss A. Barnicoat	Mr. Davison
A. Rosenfelder	G. Noble (Secretary)	Dr. Higgins
C. Newstead (Chairman)	T. Lancaster	Dr. Hilson
	S. Plint	Dr. Ng Tang Fui
R. Trembath	H. van't Hoff	Dr. Tammar
P. Cullinan		
G. Feder		

At a time when St. Olave's is being closed, the 1st M.B. course stopped and the 2nd B.M.S. examination structure revised, S.M.E.C. has a very important role. We wish the Committee the best of luck for this session.

Inter-Hospitals Gardening Cup

Guy's Hospital this year won the cup for the best large hospital garden in London. The competition is run annually by the London Garden Society and the Inter-Hospitals Cup is presented by the Worshipful Company of Gardeners. The award indicates just how effective the efforts of our lady gardener, Ms. Janet Stamp, have been since she came to the hospital less than a year ago. (cf. *Correspondence,* July and September).

Pupils' Physical Society

A meeting of the Pupils' Physical Society was held on 18th October in the Gordon museum. Three papers by Paul Fisher, Mary Ganczakowski and Mark Powlson were well received by the audience of about 30 students and staff.

The Society, which is the only forum at Guy's for students to present original research work to fellow students and staff, is keen to hear from B.Sc. and Clinical Students interested in presenting a paper at one of its meetings. Please contact Mark Stringer, Philip Razzell, or Alisdair Jacks via Boland House and help to keep the oldest students' medical society alive and healthy!

"The Times"

We congratulate the editors of *another* much-esteemed periodical upon their resumption of publication.

The Transportation of the Gazette

Our thanks to John Rapley and his men from Central Stores for their help during the move from our old offices to our new "residence" in Mary Sheridan House. Miss Nicola Foad, from Development Works & Planning, contributed in no lesser a way to this great event.

Dates from the Medical Diary

November

Mon. 26 Examinations for M.B., B.S. (Revised Regulations) Parts V, VI, VII, and VIII begin.

December

Mon. 3 Examinations for M.B., B.Chir. (Cambridge) begin.

Mon. 10 Basic Medical Sciences Examinations (1st term) begin.

Dates from the Dental Diary

November

Mon. 26 N.B. Second B.D.S. Examination may begin this week.

December

Thur. 10 Applications close for the Final L.D.S. Examination, Parts I and III.

This Month's Cover

The cover shows a line drawing of John Keats by Charles Armitage Brown (1819).

Obituary

PETER GRIFFIN, L.D.S., R.C.S.(Eng.)

The sudden death of Peter Griffin on June 2nd will bring back memories to those who were members of Guy's and United Hospitals' athletic teams in the early thirties, of a most likeable man and true sportsman.

He was a good all-rounder, the high hurdles being his chief event but he could also turn in a good performance at high and long jump, and in the sprints.

Coming to Guy's from Blundells, he was captain of athletics and represented the United Hospitals, London University and his native county of Devon.

He will be remembered for his kindness, good humour and resilient spirit which he carried into dental practice, and which must have sustained him and those with whom he served during the War.

He served as a Dental Officer with the paratroops in North Africa: later he took part in the airborne battle for Arnhem, where he was taken prisoner. The events of this battle as they affected the hospital with which Peter served have been recorded in the books and television plays written by the Commanding Officer of the hospital, Graeme Warwick.

A more adequate appreciation of Peter's professional career has appeared in the B.D.J., but it is as one who upheld the great sporting tradition of the Hospital that we wish to honour his memory.

A. E. J. E. and D. J. L.

A. E. JONES, M.B.B.S., L.R.C.P., M.R.C.S.

Arthur Edward Jones—"J" to his many friends—died on October 16th. He was 69.

The son of a clergyman, he was educated at Truro Cathedral School and Guy's Hospital. After doing house jobs at Guy's he was appointed R.M.O. Bright in 1934. He became Medical Officer to Downside School and Abbey in 1935, joining an old Guy's partnership in Somerset at the same time. After service in the R.A.F. Fighter Command in the Second World War he joined a medical practice in Bath, where he was also appointed Medical Officer to the Bath and Wessex Children's Orthopaedic Hospital, the Bath Eye Infirmary and the Royal School.

Many G.P.s are liked and admired by their patients but "J" was loved by great numbers. He was instinctively kind, very generous and a first class family doctor. Many in Bath will remember his contribution to the fun of life and in his earlier years his enthusiasm shone out like a beacon. Those who knew him as doctor, friend or both will mourn his loss and those who experienced the pleasure of talking with him through half the night will remember him with gratitude. All will extend their sympathy to Cicely (née Vick, an ex-Guy's nurse) the devoted wife who shared everything with him for over forty years.

K. E. L.

Clubs' Union News

At the Extraordinary General Meeting held on the 25th of October a majority of students voted to allow a group of students from the Clubs' Union who were attending the anti-Corrie march on abortion rights the next Sunday to carry a banner emblazoned "Guy's Hospital Clubs' Union". This meeting, which started with well over the quorum of 100 attending and finished with about 180 members present, was one of the most sensible and interesting General Meetings I have ever had the pleasure of attending. This then is probably the key, i.e. to only hold general meetings when there is an issue that is of sufficient weight or holds the interest of a sizeable minority so that the people attending fell that it is worth three quarters of an hour of their time. As a corollary to this the more mundane matters ought to be dealt with by the Clubs' Union Council, and as it so happens this is what the constitutional sub-committee (which will report in a couple of weeks) is likely to recommend.

Though the details (at the time of writing)are not finalised, it will suggest that the present Clubs' Union Council be enlarged by the addition of representatives drawn from each year of students as well as officers elected pretty well as they are now. The new Council will have the power at present vested in general meetings, that is to say it will be a policy-making body. To counterbalance this it will be made easier to call extraordinary general meetings in order to draw the attention of, or reprimand those people who will be my successors. This will inevitably mean that the number on the ruling committee will grow (from 18

to 24) but as a consequence of that the student : staff ratio will change from 13 : 6 to 18 : 6. Though a bigger committee may be more unwieldly we hope that the modest increase in size will be counter balanced by the streamlining achieved by the abolition of the termly (often inquorate) general meetings.

The new constitutional proposals will also include some alterations to bring the workings up to date, such as the abolition of the non-athletics clubs committee and the substitution of a Constituent Clubs' Committee to embrace all athletic and non-athletic clubs. Also the substitution of the Union Shop for the Book Exchange Committee. In addition the proposals take into account and include nearly all of the ideas that were the fruits of the previous administrations' deliberations. In particular the introduction of two vice-presidents (one dental and one medical), the introduction of standing orders and certain shifts of responsibility from the staff to the students. The proposals from the previous administration were if you remember *not* approved by the Governors and it would have been decided at the last Summer General Meeting what to do about this situation. But apathy intervened and the turnout of fifty people spurred us to once again look at the constitution, to see if we could find a permanent way around our deadlock.

To change tack, in the June *Gazette* it was reported that a School Council majority of three had seen to the end of the preliminary year course. At that time it was thought throughout the University that Barts would continue with their preliminary year. However it now transpires that they too intend to close down. The convenor of University of London (U.L.U.) medical group which represents the medical students in London has written to the relevant authorities at Barts and in the University expressing our disapproval and disappointment at this move and calling upon the Vice-Chancellor to honour his pledge to provide financial support for potential students of medicine to take their "A" level equivalents at another higher education centre.

The U.L.U. medical group is also concerned about the fact that the number of B.Sc. students taking the course this year has been restricted by the Medical Research Council's (M.R.C.) refusal to award more than a certain number of grants to the students who had been selected on academic merit to read for an intercalated B.Sc. As a consequence of this, at Guy's 4 students have decided to finance themselves and 2 have elected to carry on with their clinical studies and not take the opportunity that their academic prowess had singled them out as being capable of utilising. We have written to all the Deans of all the medical schools asking how the cutbacks are affecting them on this issue and also hope to hear from the M.R.C. so they can clarify and attempt to justify their action. It seems to me shortsighted in the extreme to restrict our future medical scientists and bright, highly motivated questioning individuals in this way. It is also morally indefensible to cheapen the qualification of a medical B.Sc. by making it open to those who can afford to support themselves for three terms but not to those who cannot.

Chas. Newstead,
President of the Clubs' Union.

Guy's Hospital Dental Society

"Time For Change?"—Presidential Address, 9th October, 1979

by Dr. F. P. Ashley

The theme of this year's Presidential Address was the need for change in dentistry, not only in our society in general, but also in dental education at Guy's and in the Dental Society.

Having discarded: "The more things change, the more they stay the same" in favour of "Times change and we change with them", Dr. Ashley started by considering the need for change in dentistry in our society in general. The results of the Adult Dental Health Studies indicated that the percentage of edentulous adults in England and Wales had fallen from 37% to 29% in the last ten years, and at the same time there was evidence of a dramatic change in the pattern of dental practice, with far more teeth being restored and fewer being extracted. Despite the apparent improvement we were not really seeing a reduction in disease but a change in the pattern of treatment. He pointed out that there are an increasing number of dentists working more efficiently in a repair-orientated service and unless we changed the present system we would be unlikely to achieve a large reduction in disease.

After discussing ways in which the present system could be changed, Dr. Ashley then proceeded to consider whether some of the criticisms of dentistry in general would also apply to the undergraduate dental course at Guy's. Was our course too repair-orientated? He considered it would be advantageous to try to break down the departmental barriers and integrate the clinical teaching of dentistry with a strong preventive orientation. A return to the apprenticeship concept with junior students assisting more senior students combined with an earlier introduction to clinical dentistry was also advocated.

The final part of the address was concerned with the need for change in the Dental Society. Dr. Ashley began by suggesting that one of the reasons why the undergraduate dental course at Guy's was slow to change might be due to lack of pressure from the students. He considered that the Dental Society Management Committee with its large staff membership was effectively carrying out its staff/student co-ordination role but suggested that it might have a stifling effect on the student voice. Fewer staff and more students on the committee combined with a student as President and a member of staff as Senior President was the change favoured by Dr. Ashley.

The address was received enthusiastically by the audience of staff and students who overwhelmingly declared themselves in favour of the suggested changes in the Dental Society. 58 were in favour, 4 against and 12 abstained.

The vote of thanks was delivered by the Secretary of the Dental Society, Mr. Jeremy Watson.

The Horses Of San Marco

by William van't Hoff

The unique exhibition of "The Horses of San Marco" which was held at the Royal Academy, Burlington House, closed on October 28th. For those readers who were unable to see this remarkable collection, I shall attempt to recount some of the history of the Horses of San Marco.

The four Horses are gilded bronze sculptures and are mounted on the loggia of the Basilica di San Marco in Venice. There they have stood (except for a few interruptions) since 1204, forming the only quadriga (an ancient chariot with four horses abreast) which has survived through the ages.

Above: Basilica di San Marco in Venice. The Horses can be seen above the centre arch of the Basilica.

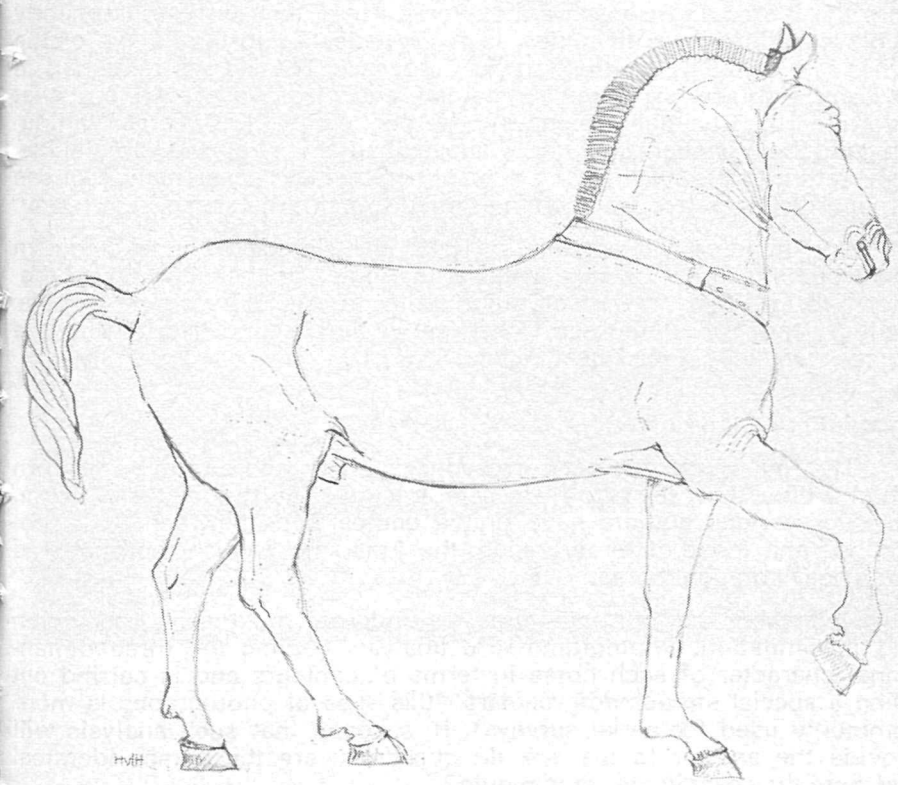
Origins of the Horses

There is much controversy over the exact origin of the Horses. It is known that they were brought to Venice in 1204 as part of the war booty captured in the conquest of Constantinople. Two years before, a Fourth Crusade had been initiated by Pope Innocent III in Venice. By coincidence, succession to the throne of the Byzantine empire was at that time being contested by several rivals. One rival, Alexius Comnenus, obtained the support of the Doge Enrico Dondolo of Venice who led

the Venetian fleet. The Crusade was therefore directed against Constantinople rather than the Holy Land. In April 1204 after a lengthy struggle against the inhabitants of Constantinople which had been impregnable for nine centuries, the Venetians attacked from the sea. At the same time crusaders led a successful infantry and cavalry assault from the land. Thus Constantinople fell.

The Horses were undoubtedly the prize pieces in the vast collection of booty that was captured. It is not known from where in Constantinople the Horses were taken. There is evidence that there were two groups of four horses in the city, one group at the starting positions of the hippodrome (the site of chariot and horse races) and another group harnessed to a chariot of the Sun. There is further debate as to whether the sculptures are derived from Greece or Rome. The favoured Greek sculptor is Lysippus who, Pliny records, was responsible for several quadrigas during the time of Alexander the Great. It is thought by some, that Lysippus created the Horses as a masterpiece for the Rhodians. Some feel that the Horses originally formed a quadriga which decorated the triumphal arch created for Emperor Nero. Lastly others have postulated that they were created as a monument to an Olympic champion on the Island of Chios and that they were removed from there to Constantinople in the fifth century.

Below: a sideview of one of the Horses. Note the very thick neck which is a characteristic of the four sculptures.



History of the Quadriga

After the fall of Constantinople the Horses were transported by warship to the Arsenal in Venice where they were stored for fifty years. At this time the Basilica was undergoing reconstruction and embellishment. The triumphal arch was strengthened and decorated and the domes converted into towering cupolas. The Piazza was also extensively altered. Midway through the thirteenth century the Horses were erected above the arch of the Basilica, the façade then took an appearance which has remained to this day.

The Horses served as references which many sculptors and artists most probably studied in great detail. Many works completed during and after the Renaissance show a great resemblance, and notable amongst these are the fifteen century equestrian monuments of Donatello and Verrochio. They also featured in several of Canaletto's paintings. In "Capriccio with the Horses of the Basilica of San Marco" (from the Royal Collection at Windsor) Canaletto removes the Horses from their true position on the Basilica, placing them instead on lofty pedestals, in order to demonstrate their importance. A painting by Bellotto (a nephew of Canaletto) is remarkable for its detailed reproduction of the Piazza, and shows the Horses in their dominating position on the Basilica.

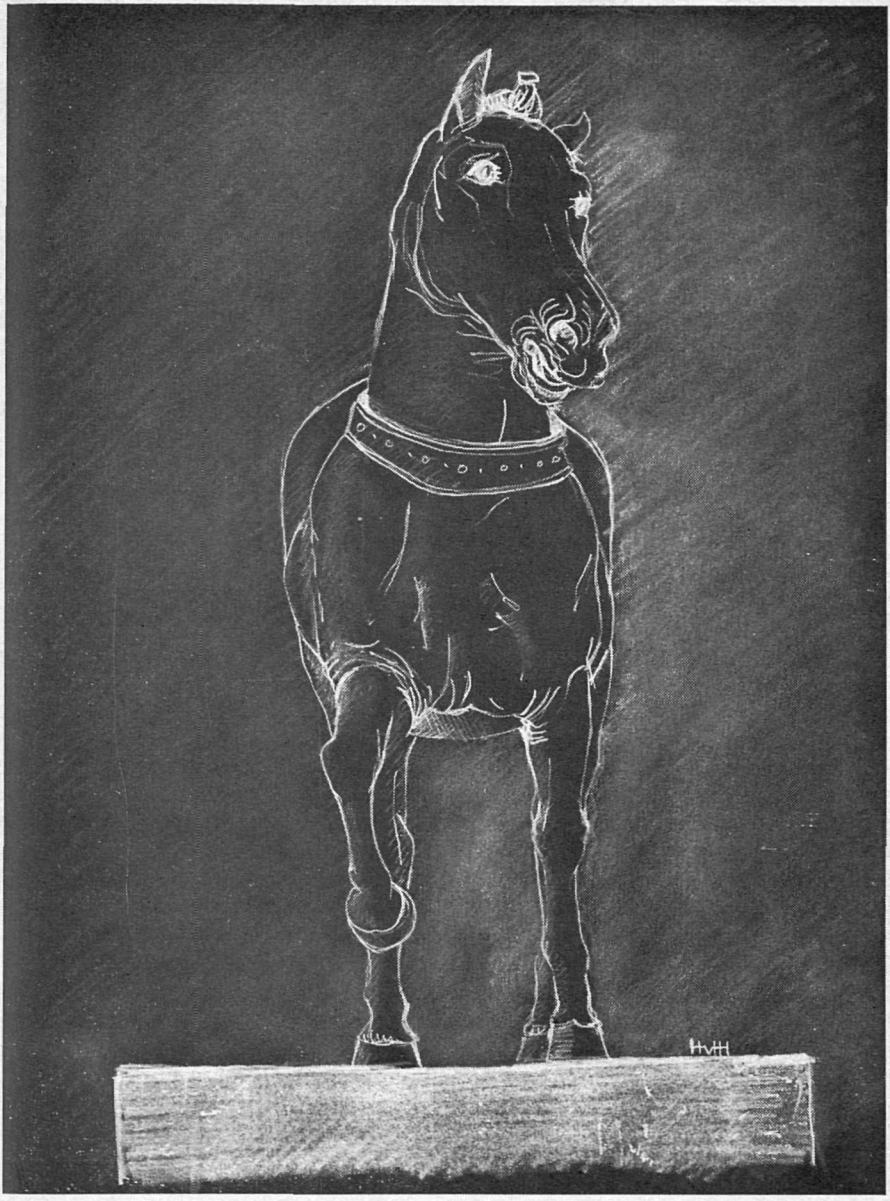
In 1797 Napoleon Bonaparte, in a defiant gesture akin to the seizure of booty by the Roman emperors, ordered that the Horses be removed from the Piazza and transported to Paris. There they were triumphantly displayed, first in Les Invalides, later on pedestals in the Palace of the Tuileries and finally on the Arc du Caroussel. The Horses remained in Paris for eighteen years until Emperor Francis I of Austria (who at that time ruled the Venetian provinces) with the help of the Duke of Wellington and the Venetian sculptor, Canova, had them returned to Venice. Their return to the Basilica was a great ceremonial occasion and Chilone (a pupil of Canaletto) was commissioned to paint the scene.

One hundred years later, in 1915, the Horses were taken down again but this time for safe keeping in Rome for the duration of the First World War. After restoration both to the Horses and to the Basilica, they were returned. Likewise in the Second World War the Horses were kept in the Ducal Palace.

Description of the Horses

The four Horses do not correspond in shape and size to any known breed, rather they seem to have been designed as the idealised horse. However various authors have drawn comparisons between their proportions and those of three breeds: the Arab, the English thoroughbred and a heavy draught horse.

At present the four sculptures are undergoing extensive renovation and investigation. Photogrammetric analysis depicts the three dimensional character of each horse in terms of contours and is carried out using a special stereometric camera (this type of photography is more commonly used for aerial surveys). It is hoped that such analysis will provide the answer to the age-old questions: are the horses identical and were they cast in the same mould?



Sketches by Hugh van't Hoff.

Radiography, fluorescence and many metallurgical investigations have been used to further characterise the Horses. No other ancient sculpture has been cast in such a rich alloy (which contains 98% copper). This alloy is very well suited to gilding with mercury: a process used for over fifteen centuries to cover alloys with a layer of gold.

Whatever their composition, origins and history there is no doubt that the Horses of San Marco form a remarkable monument. They may not conform to any known breed but they are certainly elegant. As Max Beerbohm wrote in "A Variety of Things":

"From afar they are but a note on the façade. But as you draw near . . . these horses detach themselves, stand forth, and claim all your gaze. Two on either side of the arch, each inclining his head a little towards his fellow . . . they paw the air delicately, haughtily, with a thoroughbred consciousness of their strength and beauty."

The London Medical Group

by Ian Leonard, Guy's representative

What do pornography, child abuse, transcendental meditation, virus research, Enoch Powell, and Sheila Kitzinger have in common? Very little perhaps at first glance. However they are all topics or speakers for London Medical Group meetings in the near future.

The proclaimed aim of the L.M.G. is to further the study of issues raised by the practice of medicine. It is an independent, non-partisan student group, the lectures and symposia being open to all students and others professionally interested. Practically this means that the topics discussed are typically current, ethically oriented controversies. A usual audience consists of medical students, nurses, doctors, social workers, physiotherapists and a wide range of students from other disciplines. Speakers at the meetings are drawn from a wide cross-section of medical specialities, the social services, law, moral philosophy, and moral theology depending upon the particular topic to be discussed. It is an implicit tenet of the L.M.G. that legitimate criticism can, and indeed ought, to come from without as well as within the medical profession.

The L.M.G. began modestly with a programme of four lectures in 1963—and a budget of £40 to cover all London's medical and allied students. Seventeen years later there are forty eight lectures and symposia per annum, the venue varying between the twelve London medical schools. There is an Annual Conference, the 1980 one being entitled "Death: The Last Taboo", series of study seminars are held throughout the academic year, and annual Anglo-French conferences take place. Other activities under the auspices of the L.M.G. are clinical rounds on terminal pain at St. Christopher's Hospice, and a residential conference at Windsor Great Park.

The L.M.G. was the first such group to be formed, but the idea has been taken up in Scottish and provincial centres (Edinburgh was the first to follow in 1967). The result is that now 26 out of the 29 British medical schools and university teaching hospitals are involved.

From this explosion of interest the postgraduate Society for the Study of Medical Ethics has grown, and so has the Journal of Medical Ethics. However, the original instigator of the whole exercise was student participation from the twelve London teaching hospitals, and this continues to be the main driving force.

The meetings of the L.M.G., all of which are on topics selected by students, consist mainly of symposia. The format of these is designed to encourage audience participation. Generally three speakers of differing outlooks present their views for ten or fifteen minutes each, and this is followed by at least half an hour being available for discussion. The two that will be held at Guy's next term are "The Hands of the Healer: Has Faith a Place?" on January 31st, and "Cruelty in Mental Hospitals: Is it Inevitable?" on March 27th. Other symposia include "Are Resources the Only Limit to Medicine" on January 24th where both David Owen and Enoch Powell will be speaking, "Suicide: Is it Justified?", Medicine in China", and "Childbirth at Home: Can we deliver the goods?"

The lecture lists strewn around Guy's provide additional information on all the events, but if you can't find any I will send you one if you contact me via the Boland House pigeon holes. Also if any student is interested in helping to organise events at Guy's, please contact me similarly.

Medical Report On Vietnamese Refugees Sopley Reception Centre 31st May - 9th July, 1979

by H. M. Tuddenham, Deputy Medical Officer, Hampshire branch, British Red Cross Society

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The Problem

The sudden arrival of about 550 Vietnamese refugees, people coming from an entirely different ethnic, cultural and environmental part of the world, poses a severe and complex strain on the resources and capabilities of an English community.

The lessons learnt so far have been interesting and wide-ranging and an account of how we dealt with them at Sopley Reception Centre, Hampshire, and the conclusions drawn may be of some help to other medical personnel called upon to offer their services in the future.

The Facilities

The ex-RAF Station at Sopley is situated in a rural area—the nearest village of Bransgore being about one mile away, and consisting of some dozen or so shops, a Medical Centre with two groups of G.P.s, and a small mixed population.

The nearest large town is Bournemouth, about six miles away, and the camp is very close to the Hampshire/Dorset border so that two health care districts are involved, viz. Southampton and Bournemouth, and by implication two Area Health Authorities, Hampshire and Dorset, all under the Wessex Regional Health Authority.

The camp had not been used for four years, apart from brief visits by the Household Cavalry and so a lot of work had to be done to bring it up to an operational and habitable state. It consists of a guard house at the main gate, an administrative block, a large hall (formerly the cinema), various other stores and halls, a boiler house, cook house, numerous huts accommodating about 20 people each, with a brace of kitchens to each pair of huts, and a sick bay. This has four wards (18 beds), a consulting room and treatment room, a dispensary, a utility room, waiting room, small office, kitchen and storage cupboards.

Initial Planning

The first indications that Vietnamese refugees were coming to Sopley were radio and press reports in mid May. I understand the British Red Cross Society H.Q. were approached directly by the Home Office to provide immediate care, and Hampshire Branch were duly designated.

On Thursday 31st May, 1979 Miss Balfour (Hampshire Branch Director (B.R.C.S.), her deputy Miss Pilkington and I (Deputy Branch Medical Officer) met at Sopley and made contact with Mr. Robert Hood and Brigadier Harbottle from B.C.A.R. We formally agreed to take care of the sick bay arrangements, deal with medical screening and co-ordinate the medical/nursing requirements.

Miss Balfour, Miss Pilkington and I then toured the medical centre with Mr. Crockford, Project Manager of the Property Services Agency to indicate the equipment needed for the unit. At this stage we had had no guidelines or advice from D.H.S.S. or any other agency on what to expect, on financial responsibility or organisational chain of command. Subsequently, I telephoned Dr. W. I. Densham Ray, Medical Adviser to B.C.A.R., who was most helpful in providing information on the type of ailments we might expect, the general condition of the refugees and the various steps we should consider taking.

On 6th June, a meeting was held at Hampshire Branch H.Q., Winchester, between B.R.C.S. officers and representatives of Hampshire A.H.A. and Southampton and South West Hampshire Health District to organise supplies of drugs, medical equipment and other items and discuss organisational policy for running the medical centre.

Mr. Douglas A. Quinn, Community Services Administrator, Southampton District, had been seconded for duty to help organise the operational programme at Sopley. His diligence, initiative and attention to detail was outstanding throughout and most of the burden for co-ordinating supplies, and the attendance of personnel at the right place at the right time fell on his shoulders. It was a vital role in the entire operation.

On Monday 11th June, the Red Cross personnel commenced making the medical centre operational, the building still being in a state of near chaos. By the late afternoon we were ready to receive our first patients by dint of sustained hard work in cleaning, stowing stores, erecting beds, and laying out consulting rooms and offices.

There were five entry days, viz. Tuesday 12th June (77 people), Wednesday 13th June (82 people), Thursday 14th June (85 people), Thursday 21st June (164 people), Tuesday 26th June (101 people), and Thursday 5th July (22 people). Total 531.

On each of these days we organised screening teams consisting of a doctor, a Red Cross V.A.D., and an interpreter. On one day we had two teams, on others as many as nine. In attendance also was a Public Health Inspector from New Forest District Council, who organised the collection of stool specimens when requested by the doctors.

Overall we had community health doctors providing eleven sessions from Southampton Health District, four sessions from Bournemouth Health District, and eighteen sessions from a mixture of local G.P.s, hospital registrars and retired medical practitioners. In total five Community Health Doctors were involved and eleven from other categories. The former were employed, the latter were voluntary.

The screening sessions took place on the day of arrival after the refugees had had a meal. The procedure was to visit the huts, on most occasions having been preceded by clerical officers from Southampton Health District who had filled in a primary screen form with name, age, and other personal details. The doctors then took a brief history and carried out a rapid physical check for any acute or chronic ailments. When completed, the forms were returned to the medical centre where they were separated by me into those requiring attention straight away or the following day at the surgery, and those where no action was required. Among the conditions identified were lice, scabies, fungal infections of the skin, respiratory infections, conjunctivitis, worms, diarrhoea, dental abscesses, pregnancy, hepatitis and a small number of more chronic conditions like hypertension. A lot of children had bruised buttocks, presumably from squatting on the ships in cramped conditions. At this time the Red Cross workers initiated N.H.S. Medical envelopes—F.P. 5–6, so that the G.P.s had instant documentation. The recommendations of the screening doctors were entered on the F.P. 7–8 ready for surgery consultations.

The pick up rate was:—

12th June	40 out of 79	= 50.6%
13th June	22 out of 82	= 26.8%
14th June	34 out of 85	= 40%
21st June	49 out of 164	= 29.9%
26th June	43 out of 101	= 42.6%
3rd July	5 out of 22	= 22.7%
	Ave.	= 35.4%

These patients were seen the same day where appropriate, but the majority attended the G.P.s surgery the next day. There were of course many other problems which the refugees identified themselves. During the days following admission we diagnosed about four or five cases of infective hepatitis and about three or four cases of malaria. The incidence of Australian antigen carriers were known to be as high as 20% and accordingly precautions were advised to dental and medical personnel in handling patients. A number of refugees had lost their glasses and a local retired optician voluntarily gave his services at routine clinics after agreement with the Hampshire F.P.C.

A local group of five G.P.s practising in Bransgore offered to provide primary medical care from the outset and they attended every day sometimes holding two or three surgeries a day together with clinics.

All the refugees over the age of 15 had had chest X-rays in Hong Kong and brought the plates with them. Three chest physicians from Bournemouth offered their services to screen the entire intake for T.B. The films were gathered in and read by the consultants who then Heaf tested every one of the refugees. As a result of these tests, B.C.G.s or treatment were given and something like 25 people were admitted to the Royal National Hospital, Bournemouth. Of the remainder it is estimated nearly 100 have been put on to chemotherapy either as active treatment or for prophylaxis, as it is known from previous experience that the break-down rate in immigrants is high over 5–6 years after entry to the U.K.

The positive results of the stool investigations for Giardia lamblia and worms (round, hook and whip) was high and it had been hoped to screen all new entries. However, for various reasons this did not prove possible. I very much regretted this and urged that total screening should be undertaken.

Care of Staff

All staff working at Sopley, together with local ambulance personnel, were offered polio drops and a record kept. All the field workers and interpreters were offered anti tetanus immunisation with a variable uptake by them. They were also offered Heaf tests with at least one Vietnamese interpreter who had come to the U.K. in 1975 requiring anti-tuberculosis therapy.

General Comment

Several of the Vietnamese refugees gave false names because they had had to pretend to be ethnic Chinese in order to escape from Vietnam. The boys gave falsely low ages because they had been avoiding call-up for military service. In the early days the refugees were loath to give many details about themselves, presumably for fear they would be separated from their families. As soon as they gained confidence in the medical teams they were more forthcoming, which had the effect of producing more patients for the G.P.s.

Public Health Education is a vital part of any programme and we took urgent steps to familiarise them with our habits in hygiene and social customs.

Conclusions

It is considered that a full-time camp medical officer is desirable, preferably someone with local knowledge and contacts. He needs an effective primary care team of G.P.s with nursing and administrative back-up from the outset. Ideally the medical screening and Heaf testing should be carried out together and stools investigated on all refugees. A liberal supply of interpreters is vital, both Vietnamese and Cantonese speaking, as without them chaos reigns.

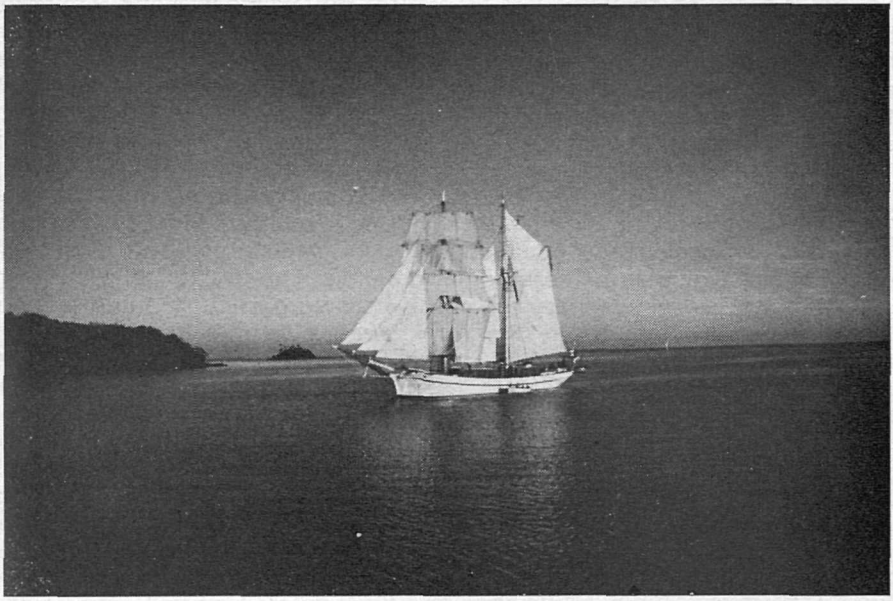
The whole exercise of looking after these people takes much longer than an equivalent number of our indigenous population and the incidence of disease, whether it be trivial or more serious, is high, putting a heavy strain on medical manpower, time resources and expertise. Co-ordination between Red Cross (or other voluntary agency),

District Health Services, and Government agencies needs to be of the highest order if the maximum return is to be obtained for a high input of effort.

On 9th July, the responsibility for running the medical centre and co-ordinating the medical requirements at Sopley was handed over to the Southampton Health District Team. The Red Cross continues to provide V.A.D. and other personnel both to help in the medical centre and with health education programmes.

Operation Drake, 1979 (Part 1)

by Adrian Penney, medical student



Above: the "Eye of the Wind" in the Yasawas

We waded ashore after a gruelling 36 hour journey in a landing craft which spent most of the time sliding back down the waves it was trying to climb. It would have been easy to wonder why we had volunteered for such an uncomfortable journey, but the welcome gave us no chance or need to speculate. We had come 200 miles south east of Viti Laevu to a small island, Moala in the Lau group to do some hurricane relief work. As soon as we arrived a Sevu-Sevu was held in our honour—this is a ceremonial drinking of Kava (an extract of the Yagona Root). In this ceremony all the men sit around the Tanoa, a large wooden bowl, the Chief presents a Tabua (whales' tooth) to the guests' chief who in return presents a Yagona plant complete with roots and stalks. The Mantanivanu, the Chief's spokesman, now makes a solemn

welcoming speech, while holding the plant, to which the Valagi (guests' spokesman) replies while the roots are crushed and then sieved through a piece of burnt cloth into cold water. By this stage the Valagi should have stopped his speech and the Mantanivanu bids the Kava to start flowing—it is handed around in a bilo (a polished coconut shell) to guest and local alternately under the guidance of the spokesman. The muddy liquid is drunk cross-legged in one gulp—the first bowel tastes not unlike milk of magnesia mixed with toothpaste—but because it has a mildly local anaesthetic effect the next bowl tastes better. Once all present have received a bilo the company breaks into a happy exchange of names, plans, stories and laughter. Now adopted as part of their family the occasion becomes more of a social than a ceremonial affair. As a novice, one can feel awkward at first, but the Fijians are tremendously tolerant and one soon learns the correct things to do, even though it may be at the expense of riotous laughter.

However we had to get down to the work in hand—building hurricane proof school buildings and teachers quarters. Hurricane Meli had struck in March and in late July we were the first outsiders to have arrived on the island. The islanders had rebuilt most of their houses but the school had not been rebuilt—they had all been too busy trying to salvage and replace what was left of their gardens, the sole source of food. Before we began, however, four of us had the honoured task of rebuilding the chief's privy—he had somehow procured a plastic seat and 'S' Bend! Working hard all day, with no let up at night as we always had a Kava session and because we were such honoured guests the girls put on a display of ceremonial dancing. The 'Meke' tells an event or tale often of love or war, each with its own particular subtle actions and gestures, the contrast between the sweet effortless tonal quality and harmonious singing contrasts sharply with the aggressive, definite, exactitude of the boys' war dances. They wield spears and clubs, grimace, grunt and shout. After these performances the dancing spirit prevails and we are all involved in their dancing, their simple invitation by touching your toes—the girls' prerogative. After three weeks we had completed two school buildings and 5 teachers' quarters. This was very hard work and by this time we were all becoming very fit. Construction work is not without its hazards and one of the directing staff unfortunately sustained a lumbar spine injury which could only be treated by immobilisation on one of the doors of the school. Indeed he was transferred back to the mainland on the door. One day perhaps the door will get back to Moula. A roof joist fell on a Y.E.'s head knocking him out and opening his scalp—this definitely needed stitches but unfortunately I could do nothing about it—it was me!

We would have liked to stay longer but we had a schedule to keep to—we had already stretched it to stay here an extra week. The farewell was a most emotive occasion. After an all night Kava and dancing session the whole village came down to the seashore, waded through the waves playing guitars, mandolins, singing, dancing, crying—as we were collected by the prime minister's yacht which only took 8 hours to return to the mainland. This was one of the projects in which I was involved for $3\frac{1}{2}$ months this summer as a young explorer on Operation Drake.

The Expedition

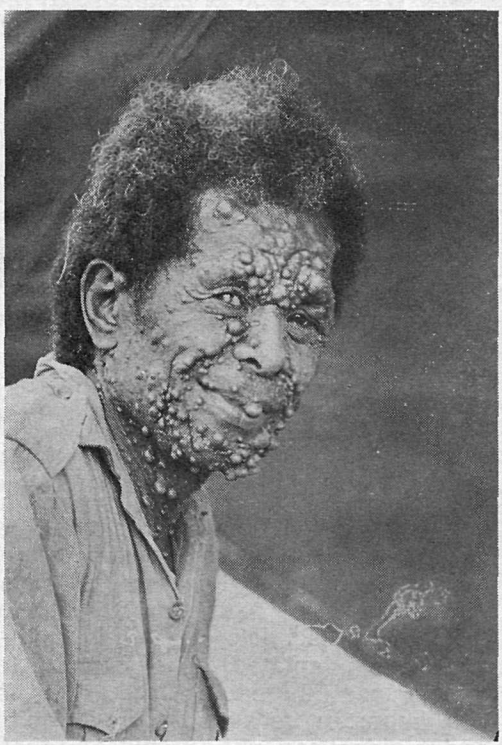
Operation Drake is a two year scientific expedition which coincides

with the fourth centenary of Sir Francis Drake's circumnavigation of the globe. It is a voyage of discovery and comparative scientific research which is based upon a sailing ship that has been fitted out as a mobile flagship and floating laboratory. The expedition left Plymouth 15 months ago and is now finishing its work in Papua New Guinea. Under the direction of the intrepid explorer Lt. Col. John Blashford Snell—of Darien Cap, and Zaire River fame—it has undertaken a curious mixture of comparative multi disciplinary projects, civil aid programmes and exploration.

The members of the expedition include seasoned explorers, scientists and Young Explorers (Y.E.'s) The Y.E.'s are a lucky 216 aged between 17 and 24 who have been selected from 56,000 applicants to take part in the expedition. 24 of these Y.E.'s take part in each of the expedition's 9 three month phases. At sea they act as seamen/women tackling exactly the same sort of problems that faced the seafarers on the Golden Hind, but in addition a lot of time is spent doing marine biology, metereology and preparation for the land based projects. On land the Y.E.'s act as assistants to the scientists, archaeologists, anthropologists and other experts who are using the expedition as a working base.

Selection

Of course these Y.E.'s needed careful selection and this had been in progress for some time. For the shortlisted candidates this included a number of arduous tasks—as part of weekend selection tests. These



Right: one of the many interesting medical cases seen during the expedition, in this photo a case of neurofibromatosis (±leprosy?).

were basically a 48 hour outdoor test of initiative, compatibility and reliability under pressure and in unusual situations. These included weighing a python, catching and measuring the volume of an elephant's foot, sexing crabs, spinning wool, darning and many other obscure tests. There were also essays to write, scientific and general knowledge quizzes, and the weekend culminated in giving a lecture. We were kept on the go continually—no chance of sleep—but whether it was tougher for us or the judges I don't know.

Those lucky enough to have been selected were to take part in one of the phases, some of which were partly land based, others partly sea based and some involving both. The main sites of scientific work were Panama, Papua New Guinea, Sulawesi (Indonesia) and the Sudan, but work is also being done on St. Vincent, the Canaries, Galapagos, Tahiti, Fiji, the Solomons, New Britain, Chagos islands, the Red Sea, Eritrea if possible and the Datilak islands. The main land based projects involve a study of the tropical rain forest with particular reference to the canopy ecology; social anthropology and local community projects of a civil aid nature; geological and geomorphological projects and their relevance and evaluation of 'Remote Sensing' which uses satellite images to provide information on vegetation and land use patterns over large areas. In Panama considerable archaeological work was done in Caledonia Bay —the site of Fort St. Andrew—the base of the ill fated Scottish colony, and also in Acla the second ever 'European' city to be built in the Americas, lost since the 16th century. The medical projects include in addition to the usual epidemiological work, comparative work on minimal light and visual activity threshold to provide more evidence of Vitamin 'A' deficiency and studies of the malabsorptian peculiar to these tropical forest areas.

—Next month: "Across the South Pacific. . . ."—

Art

A Preview of the Post-Impressionist Exhibition at the Royal Academy

From: November 17th–March 16th, 1980.
Price: £1 (students), student guide 10p, catalogue £4.95.
Open: 10 a.m.–6 p.m. (8 p.m. on Wednesdays).

The name "Post-Impressionist", coined by Roger Fry, covers many artists and many styles because there never was an actual movement. In their paintings the impressionists tried to recreate an objective "impression" of nature as it really was. This was a reaction against the romantic schools of the mid nineteenth century (which were largely technique orientated). The common feature of post-impressionist art is the personal approach of the artists to their various subjects. This was very important because it formed the bridge between objective art before and the idealised, philosophical art that followed it.

The exhibition is chronologically arranged: paintings by Monet, Renoir and Degas being in the earlier rooms while the works of the early Fauvist era (e.g. those by Matisse, Picasso and Derain) appear later. However there is a separate room devoted to the Pont-Aven period. This port in Brittany attracted many artists from all over Europe who were inspired by the beautiful landscapes and peaceful life they found there. It was after working there that Gaugin decided to live in Tahiti where he produced many of his more famous works.

I strongly recommend anybody, who has the time, to see this exhibition because it is the most comprehensive collection of this period ever gathered. Thus you have the chance to compare and judge it as a whole rather than trecking all over the world to see the major art galleries from which these paintings have come.

Hugh van't Hoff.

Nursing

Inevitably with the shortage of money in the hospitals the amount being spent on food is being reduced. Despite recent reports about the number of hospital patients who are undernourished, this will probably not do any harm, and will perhaps cause nurses to think more about the nutrition of patients and their own part in this.

In a busy ward, the serving of meals tends to be an activity that is rushed through as fast as possible so that "more important" things can be done. Unthinking nurses serve large helpings to anorexic patients who immediately feel repulsed and eat nothing instead of a little. Efficient domestics clear away before the nurses have had time to see what the patients have eaten and sometimes before the patients have had time to eat. To quote one surgeon at a Royal College of Physicians symposium on clinical nutrition: "Nursing staff are trained to make a number of physiological observations such as temperature and blood pressure, but it is often very difficult to find accurate ward records of nutritional intake or even body weight of ill patients." However, the doctors are not without blame as it is not unknown for a consultant and his retinue to arrive in the middle of a meal and stand round a patient who uncomplainingly watches his dinner getting cold. Quite apart from the importance of all this for patients care, the food wastage resulting from such lack of thought must be considerable.

The same surgeon also said: "The familiar Nil by Mouth card appears regularly on the lockers of undernourished patients undergoing various investigations", and a nursing research study when done by Hamilton-Smith in 1972 showed that many patients were starved for longer than necessary pre-operatively. Although this does not have such a bearing on food wastage, it is another point that should be considered by nurses while on the subject of food and patient care.

One of the changes that has been made at Guy's is that special diets are no longer sent to the wards on plates for individual patients. Instead, items that are suitable for a particular diet are indicated on the menu so that the patient has to select the diet and the nurses have

to serve the correct quantity. Although this is more trouble and is likely to be less accurate, it should teach nurses and patients a great deal about the constituents of a special diet.

Another change is that there is less choice on the menu. Cooked breakfast, other than a boiled egg, is no longer available and at supper one of the choices is a light meal. Also, such items as biscuits are no longer supplied to the wards. These ways of saving money seem reasonable and could probably be taken further. Patients who need extra nutrition can of course still have it and such people usually need frequent snacks and special fluid preparations anyway. But surely the majority don't need three square meals a day and biscuits at tea time. After all, most active nurses don't eat as much as that.

JULIA FABRICIUS.

Physiotherapy

St. Olave's was the venue of at least one meeting in October in which sweetness and dryness, lightness and darkness were more or less equally represented. Grace Acott, the physiotherapy superintendent, had organised way back in the innocent early months of the financial year, a lunch-cum-film-cum-discussion rendezvous for GP's and hospital staff.

Inter alia, we were trying to discover the usefulness or otherwise of the "Open" nature of the physiotherapy departments in the District, and the practitioners' expectations from a community physiotherapy service. This latter we would like to develop but of its cost-effectiveness we are still unconvinced.

It is self-evident that rehabilitation is best effected in the patient's own normal environment, and, to take the point further, that, ideally, every man should have his own therapist. Unhappily, as those of us co-habiting with our own doctor, nurse, psychiatrist, dentist, electrician, or plummer will have long since appreciated, possession (sic) is not enough. What we have to determine, if that's not too circumscriptive a word, is how best to utilise what we've got, here as in all else.

To take the "open" point first, the concept of a GP being able to refer his patient directly to a therapeutic department must make sense. The alternative is for the patient to join a weeks-long waiting list, with the possibility of his having got better before he got to the clinic. Good, you might say, when therapy was not only unnecessary but would have been expensive. But what about the lost productivity, at work or at home, which occurred during the time-lapse? We do sometimes tend to forget that idleness is itself expensive, either in terms of actual financial support or in terms of non-productiveness.

What has to be swallowed, though, is that the therapist must be granted the competence to say "yes" or "no", or "yes but . . ." or "may I suggest . . .". If we are training—as we are trying to—young women accustomed to question, to evaluate, to decide (not, please note, to diagnose) with the implied blessing of our medical colleagues, those

same colleagues must be ready to receive a question, a tentative suggestion, a decision, even, relating to the applicability of a particular form of treatment.

As to an extension into the community, we have had, for eighteen months and more, a senior physiotherapist "sussing out" the District. She has produced a report for the DMT which, in effect, says that useful work is to be done there provided that the will and the means are available. Even at the time, this met with little more than polite expressions of regret, albeit coupled with commendation, but we felt that the project merited cautious development. Not only has a third year student since been attached in order to further her education, but also a junior qualified physiotherapist has joined the team, so that some limited treatment can be added to the advice and counselling which was the effective limit hitherto.

How far such an extension can justifiably go is our next problem. If patients are kept out of hospital, or if they can be sent home sooner because domiciliary physiotherapy is available, then well and good. But it could become an expensive substitute for the outpatient treatment facilities presently available, and that would be absurd.

RONALD COOPER.

Book Reviews

"Clinical Pharmacology", 24th edition, by Girdwood. Pp. 608. Price £9.75. Published by Ballière Tindall, 1979.

Medical textbooks which have survived to the 24th edition must have special qualities. Although this certainly applies to "Clinical Pharmacology", there have been many changes in style and authorship since the first edition in 1884 (when it was Dilling's textbook). The Edinburgh Medical School has a long tradition in the teaching of Materia Medica—and this book, in its evolution, represents the changes in the teaching of the subject in that outstanding school. The Scottish tradition of excellent medical teaching is apparent in the text—with a broad and systematic coverage of the subject without getting lost in minutiae.

There are many textbooks of therapeutics, but very few which deal with clinical pharmacology (i.e. the clinically relevant properties of individual drugs) and it is this subject which approximately corresponds with materia medica.

The book provides a useful summary of the properties of many of the drugs in current clinical use, as well as mention of those whose use has been discontinued in the recent past.

R. G. SPECTOR,
Professor of Pharmacology.

"ABC of Medical Treatment", by D. C. Banks. Pp. 373. Price £6.95. Churchill Livingstone, 1979.

In recent years Churchill Livingstone have produced a number of very good medical paperbacks in the "Aids to—" series. These consist of highly concentrated information mainly in lists and tables. They have proved invaluable to those students and doctors who learn and think in this systematic manner. The book by Dr. Banks and his colleagues in Nottingham demonstrates the use of this style of presentation in therapeutics (although the book is not part of the "Aids to—" series). Much of therapeutics lends itself to summaries of procedures by lists, but there are no claims that this is a textbook of clinical pharmacology and mechanisms and actions of drugs used are not included.

The subject has been reduced to as small a volume as possible and yet the text is clear, accurate and attractively produced. As well as the expected chapters of the nervous, respiratory, endocrine systems and so on, there are useful sections on gynaecology and obstetrics, ENT, ophthalmology, dermatology and care of the dying. Although the treatment is up to date, the effective but "old fashioned" treatments are not

neglected (such as the uses of sulphur and salicylic acid cream and crude coal tar in dermatology). Inevitably, unqualified statements about any therapeutic regime could provoke debate amongst clinicians. For example, in the treatment of anaphylaxis (p. 158) many would consider adrenaline to be potentially life saving; for grand mal (p. 60) monotherapy is not mentioned and phenobarbitone and primidone are put as alternatives to phenytoin (and not carbamazepine or sodium valproate); in treating status epilepticus clonazepam and lorazepam are not included; for oral candidiasis (p. 160) perhaps local nystatin or amphotericin B would be more popular with young adults than gentian violet; should the high residue diet in the treatment of the irritable bowel syndrome (p. 52) name wheat bran as an essential component and omit propantheline from the drug treatment?

The value of the book is even further enhanced by a list of major toxic effects and interactions of the drugs mentioned in the text, and also by an index of proprietary and non-proprietary drug names.

This excellent little book might be invaluable for candidates revising with only a few days to go before their final medical examinations.

R. G. SPECTOR,
Professor of Pharmacology.

"Functional Histology", by P. R. Wheater, H. G. Burkitt and V. G. Daniels. Pp. 278. Price £12.00. Published by Churchill Livingstone.

In the land of histology there is a long-vacated ecological niche, destined to be filled by a student text book of modest price, erudite text and profuse, informative illustrations. The appearance of a new book which promises at least some of these utopian qualities is of much interest, particularly as it claims to combine the virtues of a histological atlas with a functionally-orientated text.

Firstly, it must be said that the volume is beautifully illustrated. The quality of the light microscopic preparations and the colour micrographs reflects great credit on those who prepared, selected and printed them. The line diagrams are in general equally clear and helpful, although the electron micrographs are not perhaps always of the highest standard, suffering from a degree of gloominess at times. The text is unusual in being divided between long annotations of the pictures and more systematic explanatory text; the reviewer found he was rather bewildered in places in picking his way through the alternations of the small print of the former and the larger print of the latter without any clear guide to the proper path to be followed. Some of the written material, for example that on the endocrine system, is clear and very informative, while other chapters, particularly on the structure of cells and tissues, appear to be somewhat patchy and scattered with minor errors. One notable omission is the complete absence of a section on the inner ear, even though the eye is considered in some detail.

In summary, this book is in this reviewer's opinion, a brave attempt to get away from the usual format of the student book, and provides, for its price, a most elegant series of illustrations together with a rather uneven though not unhelpful text. It certainly does not surplant either existing atlases or more theoretically-inclined text books, and it cannot be recommended without hesitation as sufficient, on its own, for all student needs in this subject.

L. H. BANNISTER.
Dept of Anatomy

"Modern Medicine. A textbook for students", 2nd edition. Edited by A. E. Read, D. W. Barritt, R. L. Heaver. Pp. 653. Price £14.95. Published by Pitman Medical.

This textbook written from the Bristol Medical School seeks to occupy the medical ground offered between the short textbook/lecture note series and the expensive reference works. Modern Medicine fulfills this function well, providing a comprehensive description of all the aspects of internal medicine, with additional chapters on dermatology, mental health and clinical pharmacology. Each disease is approached in a practical manner. There are differential diagnoses, cardinal features and managements for each and every topic listed. Indeed one criticism would be of the extent of these lists despite the profuse and possibly excessive use of diagrams. The text is pleasantly set out. Being a new publication it is expensive and the question is whether students will buy this one book or prefer a cheaper general text supplemented by specialist books. I suspect that this will be a difficult decision for some given the merits of this new textbook.

DAVID JEFFERYS.
Registrar, Poisons' Unit

"Psychological Disorders of Children", by Stewart & Gath. Pp. 167. Price $10.95. Published by Wilkins & Wilkins.

As a general introduction to Child Psychiatry, this paper-back is excellent. It is concise and reads in a clear and logical way, providing basic information on all the main psychiatric disorders of childhood.

Although this is an American book with an American style and bias, one of the authors is a well known Child Psychiatrist working in Berkshire. No doubt this influenced the choice of research work which was chosen for discussion, much of it being British.

The book can be highly recommended to all those interested in Child Psychiatry but especially to students who will appreciate the compact presentation when preparing for exams or reading up on a subject for the first time. Good references are given for more detailed study.

J. B. PEARCE,
Consultant Psychiatrist.

"The Nursing Process", by Charlotte R. Kratz. Pp. 170. Price £2.95. Published by Ballière Tindall, 1979.

In this clear, well presented book Charlotte Kratz and her four co-authors have set out to explain "the nursing process with its systematic approach to assessing a patient's needs, identifying problems amenable to nursing intervention and planning to meet them, documenting the care given and evaluating its effectiveness." As they say in the introduction, this approach to nursing meets with a considerable amount of resistance partly because many of the books about it have been written by Americans and are not always intelligible to British nurses. They have certainly produced a convincing account both of the rationale behind the nursing process and of the ways of putting it into practice, which should overcome much of the opposition.

A common objection to this method of giving and documenting nursing care is that it is fine for academics to talk about but quite impracticable in a busy ward. The book gives many examples of practical application and shows that this method can probably actually save time by making care systematic, improving communication and by making it easier for nurses to decide on priorities when there is a staff shortage.

I would strongly recommend all nurses to read this book, even if they have no interest in "The Nursing Process". It contains much information about how to give excellent nursing care.

JULIA FABRICIUS,
Ward Sister.

"Lung Sounds", by Dr. Paul Forgacs. Pp. 72. Price £1.95. Published by Ballière Tindall, 1979.

"Lung Sounds" is a short monograph outlining possible mechanisms for the production of the noises heard on auscultation of the chest in normal subjects and patients with lung disease. The author notes that although the concepts of respiratory physiology have become an integral part of clinical medicine, lung sounds continue to be discussed in the language of the nineteenth century.

The initial chapter defines clearly the noises heard and divides adventitious sounds into two groups. The continuous sound or wheeze, and interrupted sounds or crackles. This division is supported by defining these terms acoustically. The mysteries of stethoscope design are dismissed (as are the design characteristics of the majority of modern stethoscopes).

The early chapters deal with the physics and physiology associated with the generation of lung sounds and their transmission to the chest wall. The remainder of this excellent monograph is devoted to the adventitious sounds and their clinical implication in different lung diseases.

It is a useful, precise, easy to read book on sounds heard every day in clinical practice, but heard I am sure with greater insight by physicians and students alike after reading this book.

G. M. COCHRANE,
Consultant Physician.

"Review of Gross Anatomy", by B. Pansky, Fourth Edition. Pp. 524. Price £9.50. Published by Macmillan, New York, 1979.

Professor Pansky's fourth edition of his well-known textbook will appeal to many medical students because of its textual brevity and its relatively simple but excellent illustrations, which are apparently all his own work except for the radiograms. The author is convinced of the need for a three-dimensional knowledge of topographical anatomy, and the nature of this book, which is as much an atlas as a text, also emphasises his strong belief in the importance of *visual* anatomy. The programme is regional. The book also contains (apart from the index) a table of muscular innervation,

definitions of anatomical terms, a short bibliography, and a summary of regional anatomy in thirteen plates. The illustrations are largely black and white, with the use of colour for neurovascular structures where necessary. Although the reader would need some other source for the generalisations and functional correlations of anatomy, this book contains more than is adequate for most school courses, presented clearly, briefly, and in a most attractive format. Its price is not exhorbitant by current standards, and many students—and graduates—will find it most useful.

R. WARWICK,
Professor of Anatomy.

"Clinical Chemistry in Diagnosis and Treatment", by Zilva and Pannall. Pp. 492. Price £7.00. Published by Lloyd-Luke.

This is the third edition of a book which rapidly became a standard text of clinical chemistry for medical students when it was first published in 1971. The chapter on hydrogen ion and carbohydrate metabolism have been extensively revised and a new section on gonadal function added. But fortunately, this edition is no longer than the previous one.

This is an excellent book. It is up to date and clearly written with sufficient explanatory text to make the more difficult subjects comprehensible.

Medical students have a choice of two first class books: this volume or "Clinical Chemical Pathology" by C. H. Gray and P. J. N. Howorth. The latter is half the size and achieves this brevity by introducing less of the physiological background. Both can be recommended and the choice is purely a personal one. Zilva and Pannall is twice the price of Gray and Howorth but the cost of both books is just under 1.5 pence per page.

This book is available in Spanish and Serbo Croat for those who prefer to study clinical chemistry in either language.

J. LIDDELL,
Dept. of Clinical Chemistry.

"Medicine for Nurses", 13th edition, by W. Gordon Sears and R. S. Winwood. Pp. 595. Price £4.75. Published by Arnold, 1979.

The popularity of this book is testified by the fact that it is now 40 years since it was first published.

All the usual sections are included, diseases of the circulatory system, alimentary, urinary, etc., each with relevant information about the associated examinations and investigations.

Nurses are brought up to date with C A T scans (better known to the initiated as computerised axial tomography) not available in all hospitals but with which the Guy's nurses would be expected to be familiar.

I was particularly pleased with the inclusion at the end of the book of tables, energy value of foods, Latin phrases, derivation of words and common abbreviations. Useful information which the student often has to seek out in several different volumes.

Fortunately, for those of us who still think in the old conventional units, these are included in brackets beside the S.I. units.

The only reservation I have is on the quality of the black and white illustrations which, it must be admitted, are better done by a "rival" volume which also includes colour. However, the diagrams of electro-cardiograms are excellent.

Another small point is that although Crohn's disease is described on page 248, it does not appear anywhere in the index and one wonders if there are other omissions (yes, I did look under "R" as well).

Bearing in mind the cost of books today however, I think this book is good value and I would feel happy in recommending it to student nurses.

J. DOUTHWAITE,
Senior Tutor, School of Nursing.

"Brain and Personality", by G. C. Powell Pp. 113. Price £8.50. Published by Saxon House.

The study of the effects of brain lesions on behaviour has made considerable progress in recent years. However nearly all the work in this area has concentrated on cognitive processes and has more or less ignored the changes in personality, mood and motivation which can ensue. This book is therefore welcomed as an attempt to redress the balance but sadly it proves to be rather disappointing.

Perhaps a book of this type is doomed from the start since there is still considerable disagreement as to what constitutes the best way of describing and measuring personality. The author's way out of this problem is to opt for the limited personality classification based on

the introversion/extraversion dimension of Eysenck and others. As one of the apparent attractions of this model is that it is based on hypotheses about differences in C.N.S. functioning, much of the clinical evidence in the book is discussed in terms of the model and relatively little confirmatory evidence is found. In passing, there are useful reviews of the relative roles of the frontal lobes and the limbic system for personality. Although these are far from comprehensive they are appropriately critical, particularly in discussing the dubious developments in limbic system psychosurgery.

The book is fairly short and does not seem to be particularly good value, especially as it contains many misprints (e.g. "extraverting effects of drain damage"! p.90). The weakness of the contents is partly an indication of the state of the art in personality theory and in this sense the book represents a valiant attempt to present some of this. However the overall impression is of a rather muddled collection of ingredients which do not combine to form a satisfying whole. As with any meal made up from unsatisfactory ingredients, it should be taken with a large pinch of salt.

J. WEINMAN.

Lecturer in Phychology.

"Stress in Hospitals" by Wilson-Barnett. Pp. 124. Price £3.50. Published by Churchill Livingstone.

It is a common observation that the titles of many books are more grandiose than the contents. This book is a pleasant exception to this rule since actually it covers more than is immediately suggested by the title. Thus there are chapters on stress as a precursor to illness, psychological reactions to illness, community care and bereavement as well as a number of chapters on psychosocial aspects of hospitalisation. Included in the latter are accounts of psychological reactions to special tests, to surgery and to intensive care units.

All these areas are clearly and sensibly presented. The brevity of the book means that some quite complex topics are glossed over or simplified but not disastrously so. However there are fairly full accounts of some of the author's own studies of hospital life. The one surprising weakness is the limited discussion of the particular problems associated with children in hospital. Even so, this book is recommended to all those who work in hospital since it not only gives insights into the world of the patient but also contains many practical implications for management.

J. WEINMAN.

Lecturer in Psychology.

Correspondence

Sir Arthur Hurst

Sirs,

The letter from R. E. Smith, who was "H. P. in Clinical" when I was one of six who held the appointment years ago, reminded me of an incident not untypical of the somewhat executive Mr. Hurst. Hurst had a rather disdainful attitude towards surgeons and rarely came to the Surgical Ward. However, one of his own patients was, reluctantly, seen by a surgeon—I think Davis Coeley—and a laparotomy was considered necessary. Hurst decided to be present at the operation and, duly garbed in cap and mask, came into the theatre, where the patient was already on the table and D.C. poised to proceed, at which moment Hurst took out a large watch which he examined and then placed on the instrument table among all the sterilized forceps and other instruments. He clearly didn't want to waste any time and wanted D.C. to do the same.

But those who remember him will recall how well he taught and what an enormous influence he had on medical thought in the twenties.

Another story, oft related, concerns his visit to America when, having seen all the countless reports of tests carried out on an obstruse case and from which nobody could make a diagnosis, he

asked to see the patient and immediately diagnosed "mumps" or some other simple condition. It stressed his urgent plea for clinical diagnosis.

Yours faithfully,

E. D. Y. GRASBY

Fothersby West,
Hawkhurst,
Kent TN18 5DB.

Guy's in my time

Dear Sirs,

I was looking through some old medical books recently—actually Grant Massie's Surgical Anatomy for which I did a large number of drawings—and I came across these two drawings I must have made in 1922, when I was a student. Very few will remember the old Anatomy Department which stood where Nuffield House now stands (previous to that the Children's Ward) and which was presided over for many years by "Doc" Haverick. It was pretty primitive and a good deal of pickled liver was tossed on to the beams overhead! In my time Grant Massie and George Doherty were senior demonstrators of Anatomy and T. D. Johnstone, Professor (later to become Super).

The Biology Dept. was in Hunt's House at the back on the road side and T. J. Evans was the Professor—Welsh and a wonderful teacher.

You may feel that the *Gazette* could use them as a record of nearly 60 years ago and when you have finished with them the Wills Library might like them as an "ancient document"—I doubt whether there are any photographs of either of these old departments.

Yours sincerely,

E. D. Y. GRASBY
Guys 1921–1928

Fothersby West,
Hawkhurst,
Kent TN18 5DB.

Ed: see drawings on following pages

Rugby History: the legendary try

Sirs,

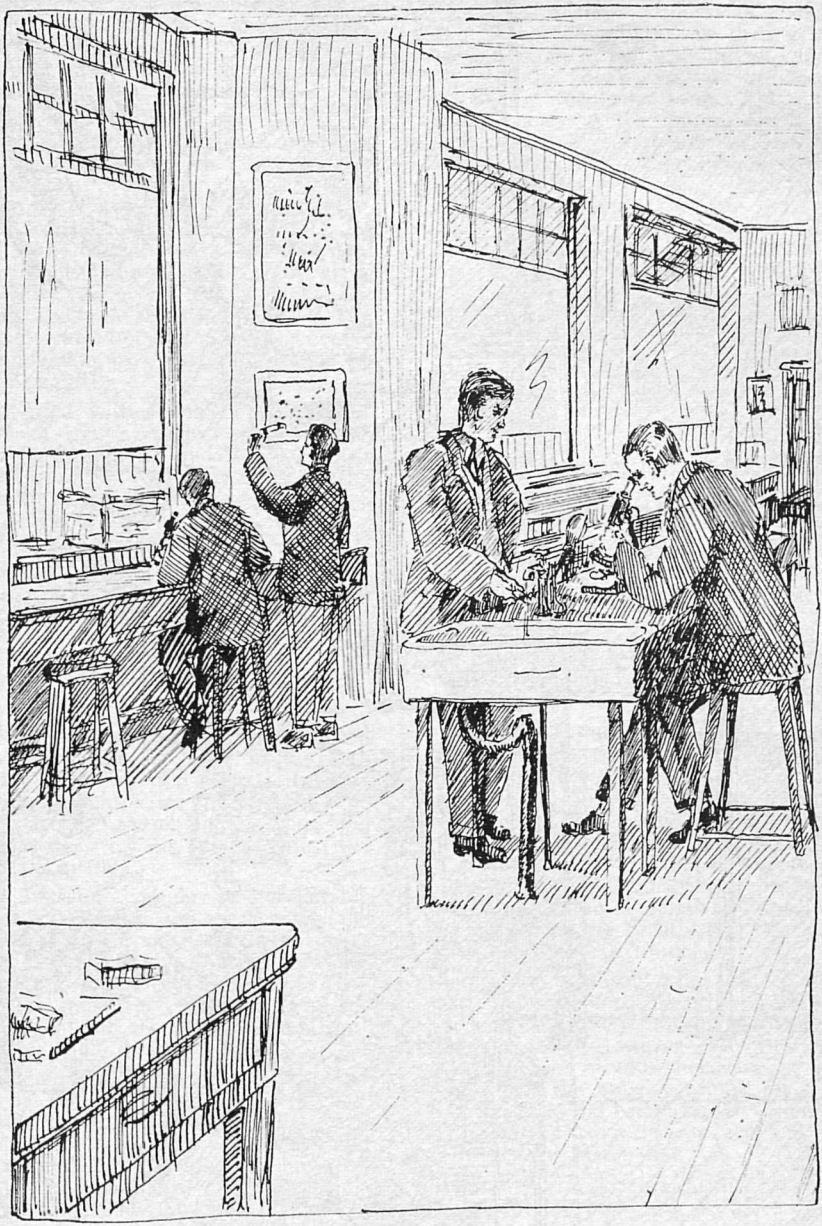
It is most kind of David Stafford-Clark to acknowledge from North Cyprus my contributions on the history of the Guy's Hospital Rugby Club which were published in the *Gazette*. In his letter (September 29th, 1979) he asks "how exactly *did* Teddy Morgan score his legendary try?"

The 1905 All Blacks, under their captain Dave Gallaher, played Wales on December 16th, having won every match so far on the tour. They had beaten Scotland 12–7, England and Ireland each 15–0. Three days after beating Yorkshire 40–0 they collided head on with the Welsh international side which had been quietly preparing for weeks how to deal with the all-conquering New Zealanders. They took on the All Blacks at their own game, kept the ball mainly in the forwards and disrupted every attack until, in the dying moments of the game, Guy's wing three quarter, Dr. Teddy Morgan went over in the corner for the winning try, 3–0. The New Zealanders, however have been disputing the result of this match ever since because of an incident which took place before Teddy Morgan's try.

J. M. MacKenzie on page 31 of his book *"All Blacks in Chains"* published by Truth (N.Z.) Ltd., Wellington, New Zealand, gives the New Zealand version;

"In this losing fight against Wales, it was William Wallace, cool-headed veteran of half a hundred games for New Zealand, who suddenly sprang like a tiger, all fire and concentrated fury, from the maddening paralysis that seemed to have gripped the side. In itself the move he made was more than 'the desperation born of despair', as an English writer described it. It was sheer intuition, the stark reaction of an unconquerable spirit to the chaos around him.

"Coming over from the left wing to stop a quick rush by the Welsh forwards from a lineout, instead of finding touch, he raced swiftly and surprisingly for the open field, cutting clean across the line of the Welsh forwards and then straightening up on to the Welsh inside backs. Alert to the danger, Gwynn Nicholls the Napoleonic General of Wales, raced in to stop him. Wallace half turned as if to meet the challenger, side stepped Nicholls in a flash, and tore down on the Welsh fullback, Winfield. In his irresistable mood, Wallace could probably have scored himself, but hearing a yell of 'Bill Bill!' from Dean, he drew the fullback and passed to Dean who went on and scored. But sensing that the referee, a quaint old-world figure in Norfolk jacket, knickerbockers and brown walking boots, was miles away, a couple of Welshmen adroitly dragged Dean back into the field of play, ball and all. When the character with the whistle arrived, he happily conceded them a scrum instead of a try for New Zealand.



Biology Lab: Guys

E. Dudley Gras Br

"Present-day New Zealanders have been regaled with other details of the story *ad nauseam* since their cradle days, such as the subsequent confession years afterward of Dr. Teddy Morgan that it was as fair a try as ever was scored, while unabashed and triumphant Welshmen for years past have found a peculiar delight in taking reverent New Zealanders to see 'the spot' on Cardiff Arms Park."

When Guy's played against Cambridge this year on October 13th I learned that the University were due to play in Cardiff shortly. I asked Tony Craigen, their Hon. Treasurer to find out what he could at the Cardiff Rugby Museum. His letter in this issue of the *Gazette* gives the Welsh version of the incident, confirming Teddy Morgan's opinion that a try was scored but throwing in a deathbed confession by Dean, unheard of in New Zealand!

The good wishes and hopes for the future of Guy's rugby expressed by David Stafford-Clark and Tony Craigen are an inspiration to the present members of the club and we are most grateful to them.

Yours faithfully,

T. L. T. LEWIS.

109 Harley Street,
London, W.1.

Rugby History

Sirs,

To take up the point raised by David Stafford-Clark in his letter in the September edition of the *Gazette*. I was prompted to do some research at the Cardiff Rugby Museum, regarding the Teddy Morgan try for Wales against the All Blacks in 1905.

The Museum contains a considerable amount of information concerning the match and the disputed try. There seems no doubt that Teddy Morgan scored a try from a pass from his centre Rhys Gabe. The controversy however surrounds whether or not the All Black, Dean, scored an equalising try.

The description of a radio interview given by Teddy Morgan and Rhys Gabe indicates that the referee ruled that Dean grounded the ball short of the line and then attempted to wriggle over to score his try. This was illegal and the try was not allowed. Teddy Morgan gave a different account suggesting that Dean had scored and then been pulled back, however the Welsh honour was satisfied by a death bed confession by Dean that he did not in fact score. Rhys Gabe tackled Dean and is quite sure this was correct.

The excellent museum contains Teddy Morgan's jersey as well as an obituary notice for New Zealand rugby!

While writing to you may I wish the Guy's team the very best of luck for the season. Those who saw them playing at Cambridge at the beginning of October thought the Guy's pack was the best we have seen for some years. There were a few holes in the centre which need attention but the manner of the team on the field promised good things for the future, and here's hoping they keep it up.

Yours faithfully,

TONY CRAIGEN

56 Trumpington Street,
Cambridge.
Hon. Treasurer,
Cambridge University
Rugby Football Club.

RAWP: defence from Lancashire

Sirs,

Over the last few months much *Gazette* column space has understandably been allocated to medical politics. Though demagogy has commendably been refrained from, the majority of the material has been written from a Guy's viewpoint. I wish to try and redress the balance.

My first point is that your continual condemnation of RAWP is misguided. Northern England, where income tax and V.A.T. are collected at the same rates, has historically had an underfinanced health service. R.A.W.P. made a genuine attempt, within a controversial area, to fairly redistribute resources. Guy's is within a relatively rich area, from which the relatively poor could reasonably expect to benefit.

In terms of absolute need Guy's, along with the rest of the health service, does have some grounds on which to ask for more money. However the criteria on which to base absolute need are far more hazy than the imperfect ones on which relative need has been assessed. Therefore I feel it makes sense to try and deal with relative need first.

The two major arguments for Guy's as a special case are as a centre of excellence, and as a teaching centre. In times of economic stringency I believe reason indicates that speculative research and newer high-cost specialities should be cut first. While this may be an important loss to the few patients who

might have benefited, the alternative, of a more general cutting of services would clearly have detrimental effects as well. These would affect a far larger section of patients who would suffer a reduction in the quality of health care (e.g. reduced nursing staff) and so in the quality of life.

As a teaching centre, Guy's role is a little less pregnable. The whole country does, and will in the future, need doctors (though whether of the type currently produced is a different matter). However even here there is a doubt as to whether economics will permit the employment of future medical graduates, at least at the ratio the profession requires.

Your exhortations to reduce administration are well motivated, and probably a partial solution. But Guy's claim to any extra finance so accrued is not great. To make the best use of present resources is of supreme importance. Such a lead is unlikely to come from the traditional centres striving to maintain themselves. A lack of an integrated policy to minimise the effects of the spending cuts politically deemed necessary means that patients everywhere will experience avoidable suffering.

Yours faithfully,

IAN LEONARD

c/o Boland House,
Guy's Hospital, SE1 9RT.

Ed: We are pleased that Mr. Leonard agrees that the role of Guy's as a leading centre of excellence should be maintained. Nothing could be fairer than to reallocate money from overfinanced areas to the poorer areas. We still maintain, however, that Lambeth, Southwark and Lewisham A.H.A. is not a rich area because of the absurdity of it having to finance three teaching hospitals. Furthermore rumour has it that money deprived from some areas under the R.A.W.P. scheme, was never actually reallocated—this is not difficult to believe when one considers the inertia and inefficiency of bureaucracy.

Approaching Nurses

Sir,

At long last, after many years of reading the *Gazette*, I have been sufficiently provoked to actually pick up pen and write. My provocation is the Nursing Section's "Welcome to Guy's—advice for medical students" by Miss (Ms.) Fabricius—September 29th, 1979.

Oh dear! How things have changed at the old place. Nurses now walk around in PURPLE dresses and have in their midst a promoter. Ms. Fabricius is even kind enough to give the number of "pretty faces" available in one year. Surely you young chaps don't need a public invitation to date these gorgeous creatures, albeit their academic achievements—higher than yours perhaps—might be a little daunting. But alas, unlike their predecessors, these new Guy's nurses could well be so exhausted by their duties that your tentative advances may be declined.

And surely, any good Guy's man knows that, until he has served years and years of apprenticeship and is finally brave enough to approach Sister, his friends on the ward are the nurses.

Come on Ms. Fabricius! Spare your colleagues' blushes. I suspect that just as many Guy's men of the future will be fortunate enough to find Guy's nurses sitting at their breakfast tables, and laughing at such puerile articles in the *Gazette*.

Yours faithfully,

ERIC M. NEWTON

Netherfield,
Round Street,
Cobham,
Kent DA13 9BA

Guy's connections in the West

Sirs,

The Western Counties Branch of the British Dental Association celebrated its Centenary on the 12th and 13th October 1979. 100 years ago the forerunner of the Branch was formed under the Presidency of a Mr. Spence Bate of Plymouth. This was a year earlier than the formation of the British Dental Association itself.

On Friday 12th October, before an impressive gathering at Plymouth Guildhall, Mr. C. K. Millman, who qualified at Guy's in 1956, was installed as Branch President. Later the audience was charmed by Lord Caradon who gave the first Spence Bate Lecture on his "Overseas Adventures".

The remainder of the week-end activities took place at the Thurlestone Hotel and culminated in a splendid banquet on Saturday evening. Among the speakers were Mr. D. G. E. Roberts, President of the British Dental Association, Guy's 1941, and Mr. K. G. Swiss, Chairman of the Representative Board of the British Dental Association, Guy's 1934.

During the week-end Professor D. J. Anderson, Guy's 1942, gave a fascinating talk on "Silver-smithing".

It was pleasing to see so many old Guy's men at this function and one hopes that graduates from the Hospital will continue to play such key roles in their professional Association in the future.

Yours faithfully,

W. J. M. HALE

Stentaway Cottage,
Stentaway Road,
Plymstock,
Plymouth PL9 7EE.

Music Club

Sirs,

After last term's excellent lunchtime recitals given by London music students in the Chapel under the auspices of the Music Club, another series has been organised. The performers this time have been drawn mainly from Guy's and the format is more informal, some of the recitals being held in the more relaxed atmosphere of the North Common Room, Boland House.

At the time of writing, the first recital has just taken place. Aric Wong, a second year B.M.S. student, amazed us with his playing in a beautiful programme of piano music by Brahms, Debussy, Chopin, Prokofiev and Chan Piu-Feng. That a medical student can find the time and energy to maintain such a technique as he displayed is remarkable.

The recitals continue until the end of November at 1.20 pm on Fridays.

Yours,

WILFRED TREASURE.

Boland House,
Guy's Hospital,
London Bridge, SE1 9RT

The Beeb at Guy's

Sirs.

Perhaps you would like to know something about the audience shows we are presently recording here at the Greenwood Theatre:—

PARKINSON on Wednesday evenings is the midweek version of the Saturday night talk show. (To avoid confusion I should perhaps make it clear that the Saturday show is **not** recorded here at the Greenwood but at Television Centre in West London.)

A limited number of tickets for the Wednesday show are available at the stage door of the Greenwood, usually about a week to ten days before the recording—personal applications only, please, and no more than two tickets for each applicant. The doors open at 7.15 p.m. and the recording is usually over by 9.15 p.m. at the latest.

FRIDAY NIGHT SATURDAY MORNING is a late night talk show featuring a variety of guests—as it says on the ticket "Stars, Wit, Conversation and some unpredictable happenings". The doors open at 7.00 p.m., the show finishes about 9.00 p.m. and is transmitted late the same night. Tickets are available for this show, the same conditions apply as with Parkinson.

You might also like to know about our third audience show: QUESTION TIME, with Robin Day and a team of politicians, journalists and prominent people, who answer questions from members of the audience. This programme is recorded on Tuesday evenings, doors opening about 6.45 p.m.

There are **no** tickets for Question Time available at the Theatre; they are all allocated by the Producer from her office at Lime Grove Studios in West London. If any readers are interested in attending this recording, a written application for tickets left at our stage door will be forwarded on to the Producer. The applications should be addressed to The Producer, Question Time, Lime Grove Studios.

I should also mention that we occasionally have a few empty seats "on the night" and if any readers are willing to chance disappointment by turning up at the Weston Street entrance of the theatre at about 7.30 p.m. for Parkinson and about 7.15 p.m. for Friday Night Saturday Morning we will make every effort to fit them in, once all our ticket holders are seated. We can, however, never guarantee admission to non-ticket holders.

We have no tickets for any B.B.C. show, radio or television, at the Greenwood, but, as with Question Time, if readers would like tickets for other shows, a written application addressed "Ticket Unit, Broadcasting House" (for both radio and television) left at our stage door will be forwarded on.

Yours truly,

TREVOR NEILSEN
BBC Theatre Supervisor

Television Centre,
Wood Lane,
London, W12 7RJ.

Sport

Our revered Sports editor, Gary Calver, despite the proximity of his examinations, has (as usual) assembled an *enormous* Sports section this month.

Unfortunately, due to the absence of the bearded dynamic duo of editors (likewise occupied), Gary became so afflicted at the prospect of being able to fill the entire issue with sport that he was unable to compose his usual introduction.

The privilege of introducing the Hospital's customary glories on these fields of battle, falls to the News Editors (those of "belligerent mood"). Our congratulations to all concerned in these sports and our hopes that they may, from their already exalted positions: "soar up with wings as eagles."

RUGBY FIRST XV

October 20th vs Old Dunstonians H.O.P. Won 7–6

Guy's gained their second victory of the season in bumbling unimpressive style, scraping through against obviously inferior opposition, by a try and a drop goal against two penalties. The forwards played a solid game with Brazier the rock on which all foundations were laid. The backs lacked that polish and astuteness required to capitalise on possession; but after an elusive run by Maggs deep into the oppositions' twenty-five, Williams cut inside to score through the cover defence. Hackett, always a reassurance behind, fielded well and dropped a cool goal from an attacking position.

October 27th vs. Cinderford Away. Lost 38–0 APPALLING

November 3rd vs. Ipswich H.O.P. Lost 26–6

The side started the match in encouraging form and found themselves 6–4 up at half time with everything to play for in the second half. The backs smarting under recent criticism, were putting a good game together, against slower opposition. Pressure brought Maggs a fly hacked touch-down, admirably converted by Ian Leonard. An Irish referee refused to acknowledge the underhand tactics employed by a suspect back-row (theirs I mean), but early in the second half their No. 7 left the field for an infamous early bath. This loss seemed to catalyse Ipswich efforts, while for no apparent reason those of the home team paled into insignificance.

November 10th vs Osterley Away Lost 10–0

With a full team ultimately taking the pitch ten minutes late, Guys' opposition were a comical conglomeration of old men and knock-kneed teenagers. But they obviously took the field with more determination and ideas, which gradually put demoralising scores on the board. The Guy's team performance was singularly unspectacular, lacked purpose, aggression, any form of decent organisation or division of labour, conciseness, alacrity or finish. An apathetic, unfit, stale and depressed team took the pitch and lost against very third rate opposition. But in the bar afterwards, excuses having been made, each player had reconciled himself to his performance and no attitudes were changed. It can only be reflected that while this is the case there is **no** prospect of improvement.

1st XI SOCCER REPORT

The story so far . . .

P. 5, W.5, D.0, L0, F.21, A.8

As the figures show, the 1st XI have got off to the best of starts this season, winning their first five league games and scoring 21 goals in the process.

Naturally, the confidence and spirit of the team is improving with each win and this was particularly evident in the win over the Royal Vets last Saturday. Despite the absence of two important 'senior' players the team worked hard and well together to achieve a notable 6–2 victory.

However, the story began weeks ago with our first league game—at home to University College.

The team quickly raced into a 2-goal lead through Mike Breeze's cross/shot and 'bullet-header' from all of one yard. However, as if to show that this Guy's side was going to be no different from previous 1st XI's, the lead was promptly thrown away. At 2–2, the game seemed to be in a precarious balance.

A happy ending to the story was provided by a superb header from Paul Sheppard and two equally well-taken goals by Dave Smalley.

The second game of the season, away against King's College, was thought likely to be a tough fixture. To our great surprise, after 10–15 minutes of the match their players had hardly touched the ball—they weren't so good after all! Unfortunately, some slack defensive work (did Andy Mitchell play another 'square' ball?) provided King's with a totally undeserved lead and it took some sterling work by Mike Breeze to snatch the equaliser.

Undoubtedly, the highlight of the match was a stunning left-footed drive by Keith Underwood which restored Guy's supremacy. It followed a great one-two movement with Simon Perkins on the left edge of the penalty box and lifted Guy's just when it mattered! When Mike Breeze added a third, the game looked well and truly won.

It appeared Dave Abraham didn't agree and, in true sporting fashion, "made a game of it" by cleverly missing an obvious clearance and presenting King's with a late goal. However, he more than made up for his mistake by somehow preventing any more goals in the hectic last few minutes. Wherever there was danger, the trusty ginger locks of Dave were sure to be seen emerging from his impressive collection of bandages.

The third win was over SOAS. Only nine of their team turned up. Dismal game. Won 3–0. Enough said.

An away game at Westfield followed the next Wednesday.

After a keenly contested opening to the game Guy's deservedly took the lead with Dave Smalley heading in a corner from Keith Underwood. Further goals looked certain as Guys played some attractive football but several chances were squandered. Just before half-time Westfield broke away and one of their midfield men was allowed to run practically into the Guy's six yard box before any challenge was made; by then, of course, it was too late.

So at the start of the second half, despite playing by far the better football, Guy's found themselves playing uphill and against a strong wind with only a 1–1 scoreline to defend. The situation worsened almost immediately with Westfield taking the lead through a disputed goal. One of their forwards blatantly fouled 'keeper Robin Evans and while Robin was still counting his ribs the ball just crossed the line.

Did Guy's have the skill and character to fight back? It is a pleasure to say that they most certainly did! Paul Sheppard cashed in on a great centre by Mike Breeze, and Mike himself scored a superb final goal after skilfully riding two heavy tackles. At last, determination to add to his skill!

With Ken Harper and Steve Robinson doing their "Dennis Smith" impersonations at the back, and the midfield trio of Alex Williams, Dave Greenaway and Dave Smalley working intelligently in defence as well as going forwards, Guy's held out to achieve a hard-earned but richly-deserved win.

The 6—2 win over the Vets, on the following Saturday has already been mentioned and in some ways must go down as the best team performance so far. Steve Robinson and Dave Cheshire both drafted into the 1st XI because more senior players were "unavailable", had excellent games. The team combined energetically and sensibly throughout the whole 90 minutes to ensure that the Vets were "neutered"!

In summary, one has to congratulate the 1st XI for their winning start to the season. It is hoped that the team realise that nothing is won yet and there is still a long way to go—but what better start could there have been?

Dave Smalley, Captain.

2nd XI SOCCER

Guy's 2nd XI has started the season with rather mixed form as may be shown by the results so far

P5, W2, D1, L2, F18, A13

The early 2 results were marred by some very slack defensive play (none more slacker than the captain, Calver). In the first match Guy's played the London and found themselves 5-1 down halfway through the second half, Graeme Smith had limped off early through the first half only to limp back on and score our goal. At that moment Guy's became transformed. Steve Robinson assisted by all, scored a hat trick and only an opponent's shoulder and the foot of the post denied Guy's an equaliser. It's a shame Guy's didn't play with as much passion and intelligence early on in the match but hopefully this shows promise for the future.

Unfortunately it didn't at least not in this match which we lost to King's 5-1.

We had a strong team on paper but Guy's played like a team of elderly hemiplegics who hadn't seen each other before. The defence, at least in the first half, appeared like a very old colander.

We were transformed magically in the next match however which I will leave to Graeme to relate.

Heartened by this result the captain put up a strong team for the next match against Bedford III's only for 4 players to disappear from the twelve on the evening before the match. A quick search around the Spit found some willing players to make up the midfield. Mick Corlett, Jon Exelby and Gary Clarke filled the powerhouse of the team very effectively indeed and Guy's through Dave Cheshire's blistering pace were soon one up. This was a hard game but one fought hard and fairly by both teams. The defence was at last playing with some semblance of solidity, however Bedford scored once in each half with one well taken goal and one care of the Guy's attack. With only 10 minutes left the Bedford defence sent the ball into a neighbouring garden. Graeme Smith went off in hot pursuit, we soon had the ball but no Graeme, in fact he wasn't to return for 10 minutes, with the excuse that the lady of the garden had invited him into her house for a short discussion on the merits of football and gardening. On his return the game commenced. Alisdair McColl took the throw in giving the ball to our lately returned hero, who lobbed the ball into the centre for 'Oldman' Earnshaw to score with a 'delicate' header and give Guy's a well earned point.

In the last game played by Guy's Imperial College IV's were beaten 1-0. Graeme Smith scored an early goal, the midfield and attack had a restful game whilst the defence of Williams, Trembath BSc, Calver and McColl was outstanding. Nick Cowland had a brilliant game (at last) and made numerous outstanding saves.

The Seconds may not be very consistent as yet, but there's never a dull moment.

Revlac.

Guy's II v. Barts II H.O.P.

After last years Hospitals' Cup Final defeat at the hands (or rather, feet) of Bart's, we were looking forward to a closely fought match. Theirs, however, was a sadly changed team, and we thrashed them. Guy's were strengthened by the presence of Andy Mitchell and Ken Harper, and it was Andy who got us underway after 10 minutes with a fine low shot to the left of the goalkeeper after a strong run from the right. The goals then came thick and fast: a cracking low shot from the left side of the box by Roger Davies, a casual lob over the goalkeeper's head from Graeme Smith, and Con Virani beating several Bart's defenders to score another. By half time we were five-nil up and unfortunately this went to our heads. The second half was (slightly) marred by apalling finishing from Guy's forwards (and defender!) The defence was, however superb throughout, with Ken Harper rampant and Alasdair McColl tackling strongly. Memorable moments of the second half were: Roger Davies striking 30 yard (alright 15) rocket into the roof of the net, Ken Harper scoring his first goal for Guy's (from the spot) and Richard Tembath missing from 0.1 cms—he said, he'd never seen a goal that close before, and got confused. Bart's managed an equaliser with a lob over Nick "I don't want a Wall" Cowland, but by then the result was beyond doubt. The only other scorer I haven't mentioned is John Rawcliffe who came to life in the second half with 2 neatly taken goals—please don't play Rugby, John.

P.S. The Sports Editor was unlucky to hit the woodwork twice with successive headers and was generally an inspiration to us all.

Graeme 'Cramp' Smith.

GOLF

v. Imperial College at Sundridge Park G.C.

Result: Won 5—1

The first match against such a large college as Imperial was viewed with a certain amount of trepidation by all. Our fears were soon realised as the opposition, unfortunately one short, proceeded to announce their handicaps ranging from 2 to 11. Dave Fish, our astute captain for the day, suggested playing off handicap; a proposition confidently accepted.

Fish, in fine form, set off against his 2 handicap opponent, in his usual bored manner and proceeded to thrash him 6 and 5 finishing with a 4-over par 73 to his furious opponent's 74. Mike Craigen, playing his usual consistent mediocrity, caught his 2 handicap opponent on an off day and dispatched him 4 and 3. Bob Heard, undaunted by his adversary's Portuguese international status, held on well to win by 3 and 2. Stuart Matthews, still trying to sell his

clubs, hit a bad patch (we still haven't found the divot) and was unfortunately beaten. Duncan Walker and Andrea Malizia, playing against their bottom player, both won well completing a famous victory against a very talented side.

v. Imperial College at Royal Mid-Surrey G.C.

Result: Won 3—2

Having scored what seemed to be a runaway victory against Imperial at home, an away match on their course was a different proposition altogether. The opposition were in a mean mood and after the previous match, were naturally unwilling to play off handicap. The Guy's team, strengthened by the timely self-selection of Nick Page, realised that they had a fight on their hands.

Page played immaculate golf and won quite easily. Dave Fish however, was unable to repeat his sparkling round at Sundridge against the same opponent, who intent on revenge, beat him out in the country. Mike Craigen, playing the Portuguese international, managed to lose fewer balls than his opponent (just!) and came out a close winner. Stuart Matthews, now trying to give away his clubs, succumbed quietly. The stage was then set for a grandstand finish and both teams rushed to the last green to find that Duncan Walker had done sterling work and beaten his opponent on the last hole.

With this third win of the season, Guy's looked set for a very successful season with the team having a lot of strength in depth.

v. The Middlesex Hospital at Sundridge Park G.C.

Result: Lost $3\frac{1}{2}$—$2\frac{1}{2}$

Flushed with three good wins already under their belts, Guy's arrived in confident mood with a strong team. The occasion was marked by Gareth Parry (yes the one who plays rugby) playing his first match for Guy's.

Nick Page, playing top, produced some well controlled golf and was unfortunate to halve when his opponent chipped in at the last. The magnitude of Nick's achievement was revealed when his opponent mentioned casually that he was the Scottish Universities champion. Dave Fish and Bob Heard were both beaten by more consistent players but Parry playing a blinder won his match 5 and 4. The match then rested on the fate of Guy Palmer and Mike Craigden. Palmer playing the immaculate golf for which he is becoming increasingly famous, won a good match. Craigen however, unaware of the crucial nature of his match, came to the seventeenth 1 down and having won that hole, looked set to win on the last. Alas he put his second shot into a greenhouse to the right of the green and lost the hole.

This unfortunate error cost the match (but luckily no harm to his wallet) and the "if only" stories seemed to be rather more numerous in the bar afterwards. The Guy's team were not too disheartened by this first defeat of the season as a strong Middlesex side had caught them on rather an off day. However, they were determined to defeat them in a return match which proved surprisingly difficult to arrange against an uneasy Middlesex side.

v. The Consultants at Huntercoombe G.C.

Result: Lost $5\frac{1}{2}$—$4\frac{1}{2}$

The annual match against the Consultants heralded a new era in Guy's golf. This is explained by two things: first, the whole team arrived on time (despite Bill Whitby taking a detour around the Oxford ring road), and second we had arrived with probably one of the best teams available to Guy's.

The format for the match was five foursomes in the morning and five foursomes in the afternoon. The match was played off handicap resulting in a significant bias towards the more consistent Consultants' side. There were several new faces in both sides and the Students were strengthened by the return of former captain Bill Whitby to the side.

The accuracy of certain players' handicaps was questioned on the first tee but finally the first pair, Craigen and Whitby, set off somewhat shakily against Dr. Hewitt and Mr. Brain. Dr. Hewitt proceeded to hit every shot down the middle of the fairway and with Mr. Brain in fine form they came out good winners. Page and Fish played well to earn a good half and with the next two pairs winning, the students were in their best position for years. Unfortunately, Matthews and Malizia just lost and the match was level at lunch.

Lunch had a strange effect on Whitby and Page who seemed to visit the trees rather too often. However they managed a good half. Craigen and Heard were

unable to capitalise on good driving and lost, overwhelmed by Dr. Hewitt's unerring accuracy. With Matthews and Lawson-Baker being beaten by a very consistent Brain and Seward, things looked black for the students. News filtered through that Palmer and Malizia had won out in the country and all depended on Walker and Fish. Despite winning the last two holes they were unable to do better than halve and so the Consultants had won.

Many thanks are due to the Consultants for providing a magnificent day of golf with probably one of the closest matches in years causing a lot of excitement.

After the match Nick Page asked to retire as captain due to B.Sc. commitments at another college and Mike Craigen was appointed in his place. Many thanks are due to Nick for his sterling work in the first part of the year and we hope that he will still be available to play for Guy's while he is away.

Results of matches

Morning:

Craigen and Whitby lost to Brain and Hewitt 5 and 4.

Page and Fish halved with Joyce and Chantler.

Heard and Walker beat Scott and Youlton 6 and 4.

Palmer and Lawson-Baker beat Houston and Lewis 3 and 2.

Matthews and Malizia lost to Trounce and Seward 3 and 1.

Consultants $2\frac{1}{2}$, Students $2\frac{1}{2}$.

Afternoon:

Page and Whitby halved with Lewis and Joyce.

Craigen and Heard lost to Houston and Hewitt 4 and 3.

Matthews and Lawson-Baker lost to Seward and Brain 3 and 2.

Palmer and Malizia beat Youlton and Chantler 8 and 7.

Walker and Fish halved with Scott and Trounce.

Consultants 3, Students 2.

Result: Consultants $5\frac{1}{2}$, Students $4\frac{1}{2}$.

HOCKEY

The season began promisingly enough with the Freshers' trials at the beginning of October. Again we are lucky to have some promising young players at the hospital this year. Notably Alan Lobo, Paul Upton, Asim Kwarjar and Richard Norris have caught the eye. Also James Gildersleve and John Dixon from Cambridge have both proved valuable recruits.

v. U.C.H. 10th October. Score: 1-1. This was our 1st match and although we did not have our full side it was a credible performance. A makeshift defence of Asim Kwarjar and Richard Norris did well with Alan Lobo, Duncan Jones and Niaz Karim working well. We led 1–0 till the last minutes in the game when a mistake by the captain proved fatal, leading to a UCH goal. Despite this it was a reasonable result for a fairly inexperienced side.

v. Peak Freans 13th October. Score: 4–1. This was our first league game in the Second Division and we came out convincing winners. Peak Freans also were promoted last year but this was a good result and our 11th league victory on the trot. The forwards, with Plowman, Jones and Wyeth linking well, proved too fast and skilful for a fairly pedestrian Peak Freans defence that crumbled like the biscuits they make. The opposition scored early on in the game but despite Garth Saward and John Pascoe's efforts they never looked like troubling us.

v. Old Borderians October 20th. Score: 2–6. This game was played on a beautiful pitch against opposition who had been demoted from the 1st division. It was an interesting encounter and although we lost badly there were stages in the game when we were on top. Guy's started slowly going one down early on. The defence again looked shaky and the Old Borderians had the midfield sewn up. Guy's settled down after 10 minutes and Jones and Wyeth worked hard in the middle creating many opportunities for Karim and Upton on the wings. At half-time the score was 1–1 after a magnificent short-corner shot from Plowman. In the second half Guy's started strongly and there was little to choose between the two sides. Old Borderians scored from a penalty corner but Guy's equalised when they were awarded a penalty which was converted by Peter Sanders who as always had a really good aggressive game at left half. Unfortunately after this Guy's tired and our defence went to pieces in the wake of some fine play by the opposition who ran in 4 goals in the last 20 minutes. Despite the result Guy's (especially Sanders) entertained the opposition with some fine singing in the bar.

v. **Midland Bank October 27th.** Score: 3–1. This was a fine victory with Guy's playing well as a team. Our attacking play was magnificent with Plowman, Wyeth and Jones outstanding. Guy's started fast and played some very good hockey in the first half creating many opportunities for themselves although not all were taken. By half time we were 2–0 up with goals from Plowman and Upton who had a good game on the right wing. In the second half we relaxed a little and allowed them to score but Wyeth put the matter beyond doubt with a good goal. Our defence played well with Saward and Kwarjar combining well at the back and Lobo and Sanders making thrusts upfield with the forwards. Pascoe in his sixth season with Guy's played well in goal and kicked strongly out of defence.

v. **The London Hospital** Score: 0–2. This was an unfortunate result against an experienced London Hospital side. Again we had difficulty turning out our full side and the opposition appeared without an umpire. The game was not particularly notable and one of their goals was yards offside. Despite this however we never really looked like scoring a goal and were well beaten.

v. **Wellcome** Score: 0–2. This was our 4th league game and a very bad one to lose. The league is at present wide open and Guy's seem to be spoiling their chances at the moment by some rather loose play. We had a rather depleted forward line and despite hard work by Johnston and Gulamali the forwards never really knitted together as a unit. The defence was reminiscent of a colander at times and hence we allowed a rather poor side to beat us. Lobo stood out in our defense and Pascoe again played well in goal.

Despite our rather indifferent performance in the league Guy's must have a good chance of doing well in the U.L. and U.H. cups this year, if all players work hard. Also Guy's was well represented in the United Hospitals' side that played against the University of London with Pascoe, Hett, Wyeth and Saward all selected.

D. Hett.

LADIES HOCKEY

Friendly Match 6th October
Guys Medics v. Guy's Physio's
Scoreline: Medics 3 Physios Nil
Scorer: Cathy Irwin (3)

Don't let the scoreline give you the wrong impression. The first half belonged almost entirely to the Physios. The midfield battle was being consistently won by them and one felt that a goal must come, especially from the very determined attacking moves down the right wing made by Julie Dinwoodie with not a little assistance from Judith Bury. However their efforts were nullified by the aggressive defence maintained by Ann Kerslake, Sîan Thomas and Debbie Unwins. Were it not for these three the physio's forays would most certainly have been rewarded. The second half started with the Medics showing a little more steam in their efforts and a series of good through balls was rewarded by a well taken goal. With this goal the Medics were transformed into hockey players once more. Although the second goal was a lucky one caused by confusion amongst the Physio's defence the third goal came from a well-earned corner which was well stopped and struck cleanly into the back of the net. . . . The match on the whole was no more than could be expected for the first game of the season but nevertheless showed promise for both sides in future games. My choice for lady of the match was Julie Dinwoodie with Ann Kerslake a close second.

ULU 7-a-side Intercollegeiate Tournament 7th October

Guy's entered 3 ladies sides in the tournament, which was held at Motspur Park, with the dual purpose of some light competition before the season started and to give the ULU selectors a chance to invite some players to attend the final ULU trials the following week.

Guy's 1st VII won their section but were knocked out in the quarter-final. The following were selected for final trials; Sîan Thomas,, Judith Bury, Fiona Clark, Sally Clark, Elaine Dare, Cathy Irwin, Debbie Unwins.

Only Fiona and Judith attended and Judith was selected to play for ULU this season. However she turned the offer down.

RIFLE CLUB

During the general rush for Sellotape and felt pens while setting up all the Club's stalls for the Fresher's Fayre, more than one voice, on seeing a table adorned with a couple of .22 rifles, slings and ear muffs, was heard to mutter "I didn't even know we had a Rifle Club".

Well, after last year's lapse into hibernation, the Rifle Club has arisen, in an attempt to grab as many unsuspecting

new members as it can. Predictably, there was much interest shown at the Fayre, as all the Freshers ran frantically around the room trying to sign on with more clubs than anyone else. More surprisingly, a large proportion of these have since come along to the range, varying from experienced shooters to complete beginners.

We use a 25 yard range belonging to the Courage Brewery, which is strategically placed just behind "The Anchor", and we usually go along on Friday evenings at 5.00 p.m., and on the odd Wednesday afternoon. We're also planning to go to Bisley sometime within the next month to do some full-bore shooting.

If you can shoot well we'd like to hear from you, or if you've never even held a riffle before you'd be welcome to come along and find out how. Drop us a line via Boland House sometime.

David Squire.

TENNIS

For those who thought they'd seen the last of tennis club reports for this season, hard luck! Did you really think that I'd let the opportunity slip to look back once more on what's been our best season since 1966? Well I won't gloat too much on how we did win both the UH cup, and UH league cup, but as you see, I fully intend to give it a mention. To get to the point, as captain there are a few outstanding thank-you's that must be said before our success dims yet more in the alcohol tainted memories of Guy's.

It is not coincidence that the team who won the cup this year were the same six who were runners-up in 1977. Practice makes . . . For a start, there's the '77 captain Jon Pringle. Newly armed with a steel racket, he played like a man of iron in the final, if a little rusty! However, as usual, Jon played uncharacteristically good tennis in time of need. Richards Plowman and Wellington have been a mainstay of the six. Plowman excells himself by breaking a racket during the knock up of each important match. Contrary to the rumours, no Slazenger has yet come into contact with Rich Wellington! Talking of Rich Wellington—he's the only player in the team who plays as if he's seen a tennis ball in the past six months. Number 4 in the team is good old "bambi on ice", Simon Moore. As always Simon came to the rescue of the team with a skill and flair that belies his true abilities. With his hemiparetic partner, Simon had the best results of the day, losing only to the London 1st pair, by 9-7 in the final set of a very hard match. Thanks Simon, for all your effort. Talking of effort, it must be said that the hemiparetic captain was trying very hard. With more hard hitting than my accuracy allowed. I must qualify for the award of "team thug"!

Lastly, in some attempt to reach a climax, thanks to Andy Morgan, our hero secretary, without whom it (tennis this year), wouldn't have been possible. Also, throughout the cold of the match, our president, Dr. Mackenzie sat riveted with distinterest and hypothermia and watched. I really must thank him for coming to support in our one moment of real success of recent years!

Final Team: Andy Morgan, Jon Pringle, Rich Wellington, Rich Plowman, Simon Moore, Tim Thurston.

T. Thurston.

LADIES WATER POLO

The ladies water polo team played a team from the Royal Free Hospital on Wednesday, 24th October. We had a good turnout and the standard of play has improved considerably since we started playing one years ago. The game was won by Guy's 7 goals to 5, the goals being scored by Tracey Maundes and Mary Ganczakowski.

As there were a number of players, substitutions were made during the game so everyone had time in. Some Freshers were playing for only the first or second time, but did very well and the game was enjoyed by all.

Team: Mary Ganczakowski (captain), Tracey Maundes, Elizabeth Palmer, Sally Brown, Sally Clark, Helen Kinsella, Tina MacFarlane, Sara Leutchford, Angela Weakes, Sian Davies, Susan Grimsdale, Jane Saunderson.

The ladies swimming club have been very successful both in swimming and water polo over the last year. We have won all but one of our water polo matches and we also won the United Hospitals Swimming Gala last summer. The number of new swimmers joining this term has been very encouraging and I hope they will continue to come along and support the club.

Mary Ganczakowski.

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The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

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Passim

Merry Christmas

The *Gazette* wishes its subscribers and student readers a very Merry Christmas and a Happy New Year—thinking particularly of those who are on duty over the festive period. Our special congratulations go to those dental students who qualify this month, and we hope that they will preserve their links with the Hospital and with their friends by subscribing to the *Gazette* in the New Year.

Sticks and Carrots

If you were one of the Final Year clinical medical students you might, about three weeks ago, have received one of those little buff envelopes with Code No. 26–149 (C6) on the top left corner, which are the hallmark of Health Service bureaucracy. Addressed not to "Mr. John Smith" or "J. Smith, Esq.", but to "Smith, J.", you might have thought, rightly, that you had received a missive from one of the highest reaches of officialdom.

In fact the envelope contained a stencilled note "TO ALL FINAL YEAR MEDICAL STUDENTS" from the Dean. It ran as follows:—

TO ALL FINAL YEAR MEDICAL STUDENTS

I am writing to inform you that you will be required to take a test in Surgery at the end of the third week of your next Surgery Firm.

Students who fail to perform adequately will be required to repeat the test and the record of students whose performance is then still inadequate will be carefully scrutinised before they are permitted to take the Final MB Examinations.

Dean.

It appears that in the light of past MB,BS finals results, which have been a source of discomfort to staff and students alike ("Passim", July 1978 and "Lancet" Editorial, August 1978), the Medical School has decided on a policy of "sticks" rather than "carrots". It is disappointing that they should find it necessary to screen our medical students at such a late stage in their careers, and in a manner further reinforcing the trend away from education towards mere "training", which has been apparent with every contortion of the overburdened curriculum. It is likewise a pity that this new policy, and the form of its communication to the students, was not worked out in rather more detail with the Student Medical Education Committee (S.M.E.C.). We note with regret that a report on surgery teaching at the Hospital, which was prepared by the student committee last year, has never received an adequate reply. In it this committee suggested that a cause of the apparent difficulties with MB,BS surgery might be that insufficient teaching was available on the firms, due to other commitments on the part of the staff, and, further, that the sources of clinical material were not overgenerous when the numbers of students to be trained were considered.

Other people believe that our students simply don't work hard enough in surgery, or neglect it in favour of more enticing specialities. There is absolutely no encouragement for such students in the news that the exam in summer 1980 will be school-based—the same rigorous standards will apply. We must hope that the present initiative from the school will encourage any slackers, if such exist, to greater efforts. Some believe that unless the test is of a practical nature it is unlikely to demonstrate the apparent weakness in basic ward work that results from the restricted experience now available to students—and it certainly won't solve the problems of reduced bed numbers and overworked staff. We look to next year's results for an answer.

News in Brief

Mr. R. J. Cann

Mr. R. J. Cann, who has been Vice-Chairman of the Council of Governors since 1974 will be retiring on the 31st of December. Mr. Cann was Chairman of the Council from 1965–74 in succession to Mr. Mollison. Dr. K. S. MacLean is to be appointed Vice-Chairman from the 1st of January, 1980 and we extend to them both our very best wishes for the future.

Guy's Hospital Society, Bournemouth and Wessex

The 24th annual dinner of this society took place at the Durlston Court Hotel, Bournemouth on Friday, 2nd November. Dr. Niels Jensen was in the chair, and after dinner introduced the guest of honour, Dr. R. K. Knight, who brought us up to date with the activities at Guy's. At the A.G.M., Mrs. M. F. Clark and Mr. E. H. Archard were re-elected Hon. Treasurer and Hon. Secretary respectively.

Goldsmith's College Big Band

The Goldsmith's Big Band, led by Don Rendell, played to a marvellous reception in the Residents' Common Room on Thursday, 29th November. The band includes Dr. Alan Jeanes, Consultant in the Department of Microbiology, who composed and arranged two of the pieces, and Mr. Mike Lavelle, Senior Registrar in the Department of Surgery, who organised the visit.

Mr. Willder

Our congratulations to Mr. Willder on his retirement after many years of service to the Department of Pathology. His invaluable work as technician, later as chief technician, including the preparation of sections & slides for research, is well remembered by members of the department, past and present.

This Month's Cover

This month's cover depicts a seasonal greeting first published in the *Gazette* of 1952. Wards may change, but the Guy's spirit lives on.

The 17th Annual Conference of The London Medical Group—Death: The Last Taboo

A conference to discuss some of the moral dilemmas surrounding death and how they affect and influence members of the medical and allied professions.

Open to students of medicine, nursing, law and the social sciences, and others professionally interested.

15th and 16th February, 1980

at the Middlesex Hospital Medical School

Fees: Students £2.00 Others £10.00

Further information and application forms may be obtained from the Conference Secretary, London Medical Group, Tavistock House North, Tavistock Square, W.C.1, enclosing a stamped addressed envelope.

Closing date for applications—8th February, 1980.

Guy's Marriage

Mr. and Mrs. P. J. Holmes.

One of the Guy's events of the summer was the marriage of Miss Joanna Wilkinson and Mr. Peter Holmes in the Hospital Chapel on August 25th. For the Holmes family it was the latest in a long line of connections with the Hospital. Dr. S. R. Trick, Peter's grandfather, was a stalwart of the Guy's Rugby Team in the glorious days of the twenties. Peter's brother qualified in medicine from Guy's last year and Peter himself is entering his final year as a dental student. We wish them every success for the future—and may the Guy's connection continue!

Dates from the Postgraduate Diary

December

Fri. 14 1 p.m. Staff Round, "Gold and the Treatment of Rheumatoid Arthritis" by Dr. B. Williams, Royal Postgraduate Medical School, Anatomy Lecture Theatre.

Mon. 17 12.30. Haematology Department Meeting, Merrivale Room, 4th Floor Guy's Tower; for details phone Ext. 2192.

Wed. 19 5 p.m. Department of Surgery, Demonstration Room 2nd Floor, New Guy's House.

Thur. 20 1 p.m. Chest Medicine Meeting, Chest Clinic, Seminar Room, New Cross Hospital. "Surgery of Emphysematous Bullae" by Mr. Jules Dussek, Consultant Surgeon, Guy's.
5 p.m. Department of Anaesthetics, Departmental Seminar, Obstetrics Lecture Theatre, 2nd Floor New Guy's House. "Demand Analgesia."

Dates from the Dental Diary

December

Fri. 14 WINTER TERM ENDS.

January, 1980

Tues. 1 BANK HOLIDAY—Medical School Office closed.

Wed. 2 STUDENTS BEGINNING THE CLINICAL PERIOD OF STUDY COMMENCE WORK.

Mon. 7 SPRING TERM BEGINS.

Mon. 21 Final L.D.S. Examination Part I begins.

Mon. 21 Entry forms for the Final L.D.S. Examination, Part II (Dental Prosthetics) (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Dates from the Medical Diary

December

Fri. 14 WINTER TERM ENDS.
Schedules for M.B., B.S. (Old Regulations) Examinations in April must be left in the Medical School office by this date.

Mon. 17 Final Conjoint Examination begins.

January, 1980

Tues. 1 Medical School Office closed.

Fri. 4 Schedules for the Final Conjoint Examination in April must be left in the Medical School Office not later than this date.

Mon. 7 SPRING TERM BEGINS.

Tues. 15 Entries close for Final M.B., B.S. (Old Regulations) Examinations in April.

The Medical School office will be closed from 24th December to 27th December inclusive.

Appreciation

Dr. Kenneth MacLean

Kenneth Smedley MacLean, son of the first Professor of Medicine at St. Thomas's Hospital Medical School, came to Guy's from Cambridge in 1936 and qualified with the Conjoint diplomas in 1939. Later the same year he graduated M.B., B.Ch. and after holding house appoint-

ments at Guy's he served with distinction in the R.N.V.R. from 1940 to 1946. He came back to Guy's as H.P. to Sir John Conybeare and during this appointment (shared with David Stafford-Clark) he acquired not

only the Membership but a fund of anecdotes which, told with inimitable skill and impeccable timing, have entertained his innumerable friends ever since. A couple of years as medical registrar followed, first with Dr. Douthwaite and then with Dr. (later Sir Rowan) Boland and during this time he was awarded his Cambridge M.D. for a thesis on pleural effusion. In 1949 he became Assistant to Boland when the latter was appointed Director of the newly formed academic department of medicine in the Medical School and in 1950 he was appointed to the consultant staff. He was elected F.R.C.P. in 1954. In 1961 he succeeded Dr. Mann as Director of the Department of Medicine and paved the way for the appointment of our first Professor of Medicine, Professor (now Sir John) Butterfield, who took over the department from him in 1963.

Possessed of boundless energy, though carrying these heavy responsibilities and fulfilling them admirably and meticulously he succeeded in building up a large practice, while at the same time writing his text-book of Medical Treatment. This first appeared in 1957 and was a *tour de force.* It was an immediate success and would undoubtedly still be a leader in this field had he not decided, wisely, that the task of keeping a work of this kind up-to-date was too great.

From 1968 to 1970 he was our first Sub-Dean of Postgraduate Studies and many of the regular postgraduate activities which now flourish at Guy's have developed from the excellent foundations he laid. In 1970 he was unanimously elected Chairman of the Medical Committee of the Hospital and Chairman of the School Council and quickly established himself in the communities on both sides of the park as their unquestioned and highly respected leader and as an invaluable link between them. The years of his Chairmanship were full of change, difficulty and threat, but his mastery of detail, steadfastness of purpose, power of decision, and admirable judgement enabled him to rise easily to each successive challenge and Guy's owes him a great debt for this outstanding service.

Following the reorganisation of the Health Service in 1974 the need for the collective views of the University Hospitals to be clearly expressed at national level soon became apparent and Dr. MacLean was one of a small group whose activities led to the setting up of the University Hospitals Association. He became the first Chairman of this important national body, and the status it enjoys in the medico-political affairs of the country today owes a great deal to the wisdom and foresight he displayed during its formative years.

As a general physician he enjoys an enviable reputation, inspiring unswerving devotion from his patients, and deservedly he has been one of the most popular teachers of his generation at Guy's. It was characteristic of him that when St. Olave's Hospital became part of the Guy's Group, he volunteered to transfer his beds and outpatients there and quickly built up a first class teaching firm. Few indeed would have sacrificed their own convenience in this way.

Golf has been his chief relaxation, though this word is perhaps inappropriate to one who sees the game as a test of moral fibre rather than a pastime. He was a member of the Guy's golf team as a student, later for many years President of the Golf Club and in 1978 the Guy's

Open Champion. He has few equals in competitive spirit, possessing the extremely rare ability to play better in adversity.

A staunch friend and a witty and entertaining companion, he will be greatly missed at Guy's. We wish him a long and happy retirement.

J. C. Houston.

Obituary

THOMAS GILBERT SCOTT

Thomas Gilbert Scott died at his home at Peasemore, Newbury, on November 10th. He was 76.

Eighth of the ten children of Dr. Bernard Scott, a well-known Bournemouth surgeon, he was educated at Bradfield in Classics and English and came to Guy's in 1922. He qualified with the conjoint diploma in 1927 and became F.R.C.S., Ed., in 1933, in which year he joined Dr. David Kennedy in general practice at Newbury and remained there in a rapidly increasing partnership until his retirement in 1967.

Those who remain of his contemporaries at Guy's will always remember him for his immense zest for life and his companionship. Tom had a deep love of the countryside and was an expert ornithologist. He was also an accomplished landscape gardener.

He belonged to an era of non-specialism and in the wide-ranging scope of his practice brought comfort and compassion to patients in all walks of life.

A devoted and much loved family man, he leaves his wife Elizabeth, their five children and sixteen grandchildren.

E. C. T.

STEFANUS HOFMEYR DANEEL, M.R.C.S., L.R.C.P.

"Fanie" to his friends and family, "Sihlutu" to his Msinga Zulus, died in Pietermaritzburg, South Africa, on July 1st, 1979. Here was a strong personality, kindly and modest but with deep religious convictions. For most of his life he worked among the Zulus in the Msinga and Helpmekaar regions of Natal. He lived in Pomeroy, a singularly unattractive village, and he knew all about the appalling roads and inclement weather experienced by so many district surgeons in remote areas.

Fanie was born on May 16th, 1896 at the Zoutpansberg Dutch Reformed Church Mission near Louis Trichardt, matriculated at Stellenbosch Boys' High School, and after a year at the University of Cape Town went overseas to continue his medical studies at Guy's. While there he was a member of the famous Guy's Hospital rugby sides of the early 1920's (he was one of the crack South African players at Guy's during this time).

On qualifying, Fanie was appointed district surgeon in the Msinga and Helpmekaar districts, and he laboured in this capacity for 30 years. On "retirement" his great ability was quickly recognised by the Natal Provincial Administration and, in spite of his 60 years, he was appointed

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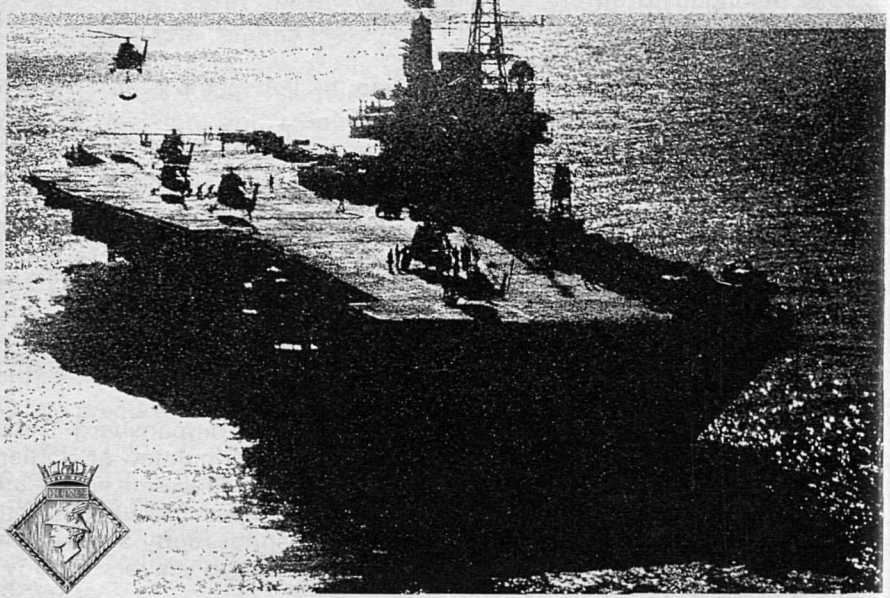
If you'd like to know more, write giving details of your age and qualifications to: Surgeon Captain (D) F.R.B. Mathias RN (26DC), First Avenue House, High Holborn, London WC1V 6HE.

ROYAL NAVY DENTAL CADETSHIP



HMS HERMES – 28,500-TON ANTI-SUBMARINE CARRIER.

as a foundation member of the staff of the East Street Clinic in Pietermaritzburg, the great success of which largely stands to his credit. He finally retired a year before his death.

The Msinga Zulus are regarded as rather turbulent people, among whom faction fights have been a sort of recreation for many years. Fanie was in the midst of these. His courage allied to his skill and compassion made him loved and respected by all factions, who looked up to their *Doketela Mkulu* with deep affection and respect. The Gordon Memorial Mission and the Church of Scotland Hospital at Tugela Ferry owe him much—the Hospital, especially, he saved from disaster many times during its recurring years of difficulty.

His wife Jean is a daughter of the Gordon Memorial Mission, and had the unfailing support of her husband in her tireless and devoted charity work in his district and later in Pietermaritzburg.

To Jean and to her son John and daughter Margaret we offer our deep sympathy. They, like everyone who knew Fanie, will be comforted in the loving remembrance of the skill and devotion of this gentle physician.

R. E. S., R.D.

Clubs' Union News

The twenty-second of November saw another grossly inquorate general meeting. This was especially disappointing following the well attended and stimulating Emergency General Meeting on the Anti-Corrie March held just a month previously. The way we are attempting to change this is to alter the whole structure of the Clubs' Union constitution. This received considerable publicity and fulsome praise from the *Gazette* (Passim, Nov. 1979). I have always been suspicious of the way students continually tamper with their Union constitutions and the case of the University of London Union has reinforced this—for I see, especially in the latter example, this as symptomatic of the inability of the officers to get on with the job at hand. To continually claim that it is the constitution that is restraining one is often cowardly and incompetent.

This problem of inquorate meetings is one that besets all Student Unions (let alone Trades' Unions and many other similar organisations). Other students have resorted to holding the meetings in the bar (during opening hours) or providing a free barrel of beer or sandwiches. These possibilities have been considered at Guy's before, and indeed were discussed at the latest constitutional sub-committee. However we felt quite strongly that such tactics were frivolous ways of coercing people into the serious business of delineating policy for a representative body. Another method would be to engineer a topical or controversial motion onto the agenda; this is what in fact happened last year. But all the motions proposed emanated from the officers on the council, and although I think it is appalling that we as a body have no policy on the Health Service cutbacks in general and the closure of St. Olave's in particular, I have not encouraged officers to present such things to

general meetings. Such a move ought to come from interested individuals in the student population. Obviously there are not enough people motivated enough to do this.

This seems a real shame, because the voice of Guy's students does carry weight especially with regard to local issues. For instance we were mandated at the last Annual General Meeting (in a motion proposed and seconded, characteristically, by the outgoing and incoming Presidents respectively) to fight to preserve the preliminary year. Although this has of course now been stopped, the interest of the students has allowed me to badger the Dean about contacting the Cloth Workers' organisation and another trust to set up a fund to help support graduates through education at Guy's. He has also, I was delighted to learn, reminded the Vice-Chancellor Lord Annan about his commitment to set up a way of financing worthy applicants through science courses at other colleges.

The tenor of this "news" seems to me quite uncharacteristically negative for that is not the way I feel about the trials of the Union this year at all. The example of the preliminary course in fact may well turn out to be a success but this is dependant on what the University decides to do. Guy's students have I think been well served by their officers even if they are completely unaccountable for the things they have tried to do. The successes are of course very very rewarding and all those involved in the organisation have received generous praise from the consumers. This is, as you will have by now realised, a plug for the elections for new officers the nominations for which open on the second of January. It would be gratifying and very healthy to see the posts contested by able willing individuals. To serve in this manner is excellent experience as it will broaden your outlook immensely. Not only do you become accustomed to dealing with situations you had not realised you were capable of coping with, but you also get introduced to the decision making machinery of the College and like institutions. And last but by far the most important, you have a great deal of fun.

The Hollywood (Snowflake) Ball

As I am writing this I am still recovering from the Hollywood Ball which I am relieved to say was a very considerable success. Looking back with the hindsight of some thirty hours it is impossible to pinpoint what it was that was responsible for the near perfect running of that night. That aside, five hundred guests were fed and some six hundred people were all entertained by a Jazz Band, a Reggae Band and a Rock and Roll Band, were serenaded during the meal by a "Gypsie" trio and later amused by Bob Kerr's Band; the finale being supplied by Billy J. Kramer and the Dakotas. A very impressive disco, the Powerhouse Roadshow, provided the continuity. The decorators had transformed Boland House in theme with a variety of Hollywood "Classics"; the bar was a Western Saloon and the Upper Spit a Science Fiction fantasy. The rest of the building was a mishmash of ideas but with our logo repeated at intervals to maintain some degree of identity. The evening finished off with the more robust watching three films into the early hours. All the decorating and the catering as well as the entertainments and the overall

organisation was done by students. I think those responsible ought to receive every recognition:—

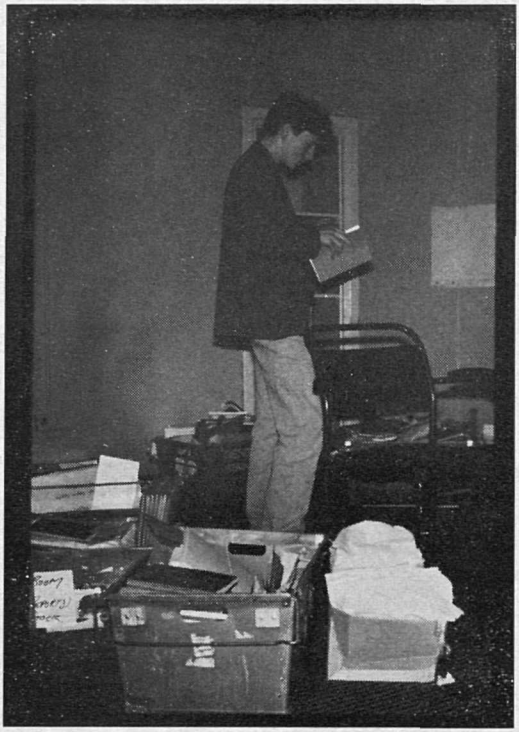
D. Brooke, catering mastermind; M. Poynton, K. Johns, D. Denning, T. Dean, C. Scott, chief cooks; G. Wilcox, N. Crofton, B. Pilkington, cooks; K. Harper, M. Powlson, J. Drewry, M. Bowman, M. Illingworth, helping on the night; A. Kumar, invaluable at all times; C. Donovan, posters, publicity, ticket sales and table allocations; P. Bearn, film organiser; I. Collins, R. Potter, lighting; R. Long, the bars; R. Horne, the entertainments; A. Stebbing, decoration mastermind; N. Meridith, N. Cooke, N. Cliff, C. McEwen, C. Smith, D. Murdoch, R. Hurrell, decorations; A. Barraclough, W. Carlile, N. Morgan, were some of the heroes who helped clear up afterwards. Also Miss Redsell, catering advice; Mr. Fendick, accounts advice; Mr. Bompas, for solving insoluble problems; Mr. Wheeler, for preserving the fabric of the building. Also all the waiters/waitresses, the bar staff, security men, fire watchers who kept it all running. The Works Department and the Boland House cleaning staff were very sympathetic and also deserve our thanks.

Chas Newstead.

The Great Move

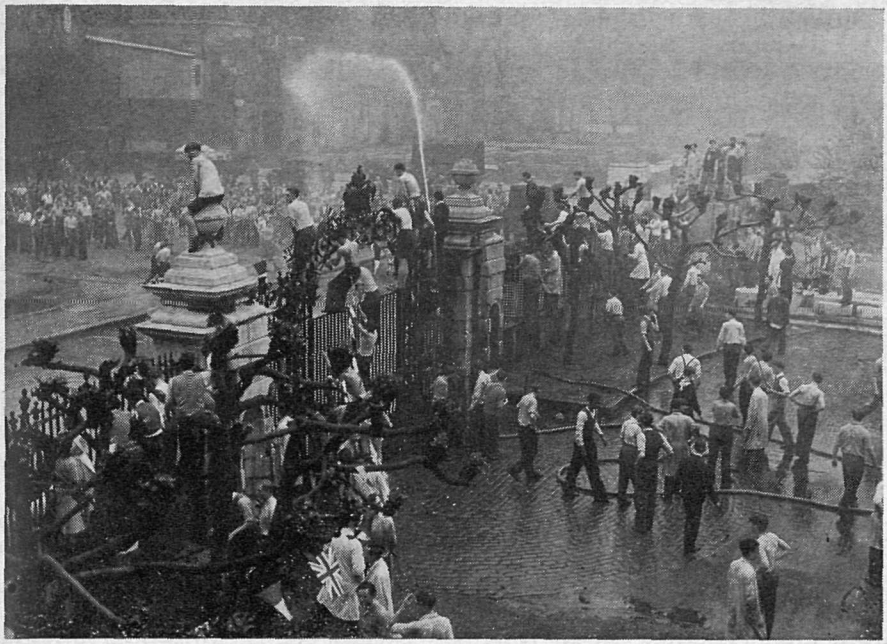
On the 1st of May, 1956 the *Gazette* moved into its rambling offices in 16 St. Thomas' Street, shared with the Guild of ex-Patients, later to become the League of Friends. These offices (seen from the outside in the first picture, our door next to the whitewashed building) were our home

for twenty-three years, during which time a considerable amount of lumber was accumulated—all of which was carted across the road to Mary Sheridan House on November 4th, as was noted last month. During the chaos of the move (see below), a great deal of interesting and forgotten material turned up, including some fascinating old prints, pictures, and a few more copies of Maurice Campbell's monograph "Sherlock Holmes and Dr. Watson, A Medical Digression", which we hope to serialise next year.



Above: the Arts columnist amidst the débris.

The examination of these will take some time, but we confidently expect to be able to publish several of the "discoveries"—and it is with one of these that we will leave you, taken in the forecourt two days after VE day, when King's students were successfully repulsed.



Above: VE day plus two: Guy's wins a different war.

The Office of Superintendent

by **Dr. P. Helliwell**

This article is based on an address given by the writer at the 543rd meeting of the United Borough Hospitals Club.

The term United Hospitals came into use during the latter part of the eighteenth and early part of the nineteenth century. Although medical students officially joined one or other hospital, they attended St. Thomas' to learn anatomy and surgery whilst medicine and allied subjects were taught at Guy's. In surgery particularly, students who were "apprenticed" or appointed dressers paid a fee for personal instruction directly to the member of the staff concerned. Lecturers also pocketed their students' fees and trouble started when Astley Cooper, a Guy's man but the mainspring of anatomical and surgical teaching at St. Thomas' appointed his nephew Bransby Cooper to succeed him. He, like other lecturers,

regarded this as his right (and usually extracted a fee for doing so), but the Treasurer of St. Thomas' had other ideas and appointed Mr. J. F. South. This and other matters created considerable ill feeling and relations between the staff of the two hospitals became very strained.

The great "King" Harrison, Treasurer of Guy's, solved the difficulties by proposing the foundation of a separate medical school at Guy's. It was not until the famous fight in the operating theatre of St. Thomas' between students of both hospitals that the final rupture took place.

On St. Valentine's Day, 14th February, 1828, two years after the opening of the new school at Guy's, the United Borough Hospitals Dining Club was formed when 22 gentlemen from both hospitals met at the London Coffee House, Ludgate Hill. Golding Bird set out the object of the Club as follows:

> "To keep alive the traditions and memories of the past; to perpetuate old and to create new friendships and to prevent the extinction of the brotherhood that had existed for a century between the neighbouring hospitals of St. Thomas' and Guy's."

In this address I have tried to trace the origin of the post of Superintendent at Guy's and to say a little about the men who have had the honour to hold the office.

The governing body of Guy's in 1725 was modelled on the existing arrangements at its parent Hospital. The nine Executors and fifty-one gentlemen nominated in Thomas Guy's Will became a "body Politic and Corporate by the name of the President and Governors of the Hospital founded at the sole cost and charges of Thomas Guy Esq.". This General Court of Governors nominated the 21 members of the Court of Committees, seven of whom were to go out of office each year. The President and Treasurer, Physicians, Surgeons, the Clerk and the Chaplain were elected by the General Court but the Court of Committees was responsible for the rest of the administration of the hospital. In the Report of the Charity Commissioners on Guy's in 1840, it states:

> "None of the Governors derive any emolument or perquisite whatever from the office except the Treasurer for whom a commodious residence is provided in the Hospital, with coach house and stabling, and coals, and beer and candles for his servants. The only privilege they enjoy is the right of each in his turn recommending a lunatic for admission to the Hospital."

Benjamin Harrison was Treasurer of Guy's from 1785–1797. He was obviously of comfortable means but I have been unable to discover the source of his wealth. An ancestor in Burke's Landed Gentry is described as a "very rich man". His son, also Benjamin, came to live at Guy's when he was fourteen. He was elected a Governor at the age of 21, served on the Court of Committees, succeeded his father as Treasurer in 1797 at the age of 26 and held that office until he retired in 1848. During his reign he was nicknamed "King" Harrison: he virtually ran the Hospital and School as a dictator using the Court of Committees simply to rubber stamp his decisions. There is no doubt "King" Harrison must have been a very remarkable man. He was also a Governor of St. Thomas' Hospital and, despite the major part he played in the breakaway when Guy's formed a separate school, remained not

Benjamin Harrison, junior,
after George Richmond

(by kind permission of the Wellcome Institute)

only on their Grand Committee, the equivalent of the Court of Committees at Guy's, he was one of the Auditors, a post which gave him a permanent seat on that Committee. It is interesting to note that not a single letter or copy of a letter written by or to Harrison has survived in the archives. Whether they have all been destroyed or that he simply avoided the use of correspondence as an instrument of administration we do not know. It is not surprising that the Charity Commissioners took the view that although they had no criticism of Mr. Harrison personally they did feel that the office of Treasurer to the Hospital was entrusted with too great authority.

"One most important subject yet remains to be noticed, namely, the absolute and uncontrolled authority which is practically enjoyed by the present treasurer in every department of the charity; not only are the administration of the hospital, and the management of the funds entirely in his hands, but the nomination of governors seems mainly to rest with him, a list being usually tendered by him to the other governors. The additions which have lately been made to the Southwark estate have mostly been contracted for by him in his own name in the first instance, and then tendered to the governors on the same terms, which in fact is only a colorable method of purchasing on behalf of the hospital on his own authority. No opinion is offered on the expediency of these purchases, but transactions involving such large pecuniary consideration should not be abandoned altogether to the discretion of any single individual.

"It has already been mentioned, that the entire control of the medical school has been formally delegated by the other governors to Mr. Harrison in his private and individual capacity. He names the lecturers, and exercises a sovereign and irresponsible authority in the distribution of the funds arising from the pupils' fees; so large a concession appears to us unjustifiable. Not only is this great school of medicine thus wholly delivered up to Mr. Harrisons' discretion, but the physicians and surgeons of the hospital being practically selected from the lecturers in the school, their nomination is virtually surrendered to him.

"The present arrangement is also defective, in permitting the hospital monies to be kept in the private name of the treasurer, from whom no security whatever is required.

"In submitting these remarks, it is but justice to Mr. Harrison to state, that his whole time, talent and energies have for above forty years been devoted to the service of the hospital, and that the entire course of his administration has been marked by zeal the most active and efficient, as well as by the most scrupulous and disinterested integrity. The presentation of his nephew to the living of Beaumont took place without any intimation of a wish on his part to that effect; and not only have his services been gratuitous, but his connection with the hospital (in the absence of a fund for the assistance of distressed patients on their discharge, the want of which seems to be seriously felt) has proved to him a constant source of expense, numberless destitute persons having been relieved by his private benevolence. We are far from being prepared to show, or even to suggest, that the interests of the charity have, as yet, suffered under the above extraordinary delegation of authority to this

gentleman; but a successor equally qualified and willing to make similar sacrifices with him is not likely to be found when it may become necessary, and much confusion and injury may then not unreasonably be anticipated, as the result of the system of total non-interference on the part of those who nominally held the administrative power of the establishment."

In 1847, Harrison acknowledged to the Court that it was unlikely that a successor would be found, who as a Corporate Trustee and, therefore, not eligible for remuneration would be willing to undertake all the duties he had shouldered and proposed that "The Treasurer be authorised to employ and remunerate any officers of this establishment, or other persons in conducting or performing any service for or relating to this Institution which is not required to be performed by a Governor or Trustee."

"At the meeting of the General Court held on 2nd November, 1848, Mr. Bonamy Dobree was elected Treasurer to succeed Mr. Harrison. But even before his appointment the Court had taken steps to carry out Mr. Harrison's valedictory recommendation that a salaried Superintendent should be appointed. On 18th October, 1848, a fortnight after the Treasurer's resignation, it was 'Resolved that it is the opinion of the Court that a gentleman who is not a Governor should be appointed, with an adequate salary, to superintend the internal management of the Hospital. That a sub-committee of Governors be now formed to consider the salary to be annexed to the office of Superintendent and to prepare the rules and regulations for the future government of the affairs of the Hospital.' The first to be nominated to serve on the sub-committee was their late Treasurer, Benjamin Harrison."

Although this sub-committee recommended the appointment of a salaried officer, it was not until some years later when the Steward, Mr. James Browell, resigned that an opportunity occurred to alter the administrative arrangement.

The minutes of the Court of Committees held on Thursday, 4th day of August, 1853 record—

"That your Committee are of opinion that the resignation of Mr. James Browell, the Steward of this Hospital, affords an opportunity of making changes in the Administration of the Internal affairs of the Hospital and they recommend an order to effect such changes that a person to be called 'Steward and Superintendent' be appointed, to whom should be given, under the direction of the Treasurer and the Taking in Committee, the entire control and management of the Hospital with power to enforce the observance of all regulations ordered by the Court of Committees or the Treasurer and to suspend any Officer or Servant for neglect of duty, such suspension to be forthwith reported to the Treasurer.

"That the person to be appointed 'Steward and resident Superintendent' should be between the ages of 30 and 45 years and that preference should be given to a candidate who at the time of his primary election should be unmarried and without incumbrances."

The post was duly advertised at a salary of £400, plus residence. 97 applications were received and ten were short listed.

"The Committee unanimously resolved to recommend to the Court of Committees, John Charles Steele, M.D., Superintendent of the Glasgow Royal Infirmary, to be chosen Steward and Superintendent of Guy's Hospital."

The sub-committee believed that it should be possible to find a gentleman "of good social position, of high administrative ability and of experience acquired in the Army, Navy, the Indian or Civil Service, or elsewhere, who would devote a large portion of his time to the good of the Hospital, as Treasurer, residing in the house provided for him and accepting a moderate allowance." St. Thomas' Hospital were faced with a similar situation a little later but the solution they favoured was slightly different despite the recommendation of the Charity Commissioners that a paid Superintendent be approved and it was tentatively suggested that the Treasurer should be paid.

Cuckulidian Grimm, Medical Fable, Part II

by Mr. M. Laurence, Consultant Orthopaedic Surgeon

And so Mr. Starling, realising the error of his ways, thanked kind old Matron Owl for her wise advice and set about doing as he was bid. He cared for and cossetted all the elderly cuckoos in the hospital nests of the wood, long after they were made better from their illnesses, and instructed his helpers to do likewise. He arranged for the larks and nightingales to make music for their endless entertainment and persuaded them to stay in the nest rather than venture out of their warm dormitories. And none of them came to any harm just as wise old Owl had forecast. So successful was he that he arranged for the birds of burden, like the Stork, to give up their customary loads and go out and fetch all the mangy old birds whose feathers were falling out, and bring them in to the hospital nests to be cared for. The other healthy birds would forage food for them and busy themselves trying to stick on new feathers where the old and grey ones had fallen out.

Bye and bye the hospital nests became filled to overflowing with fat and flightless old boilers, squawking away angrily at being taken away from their own cosy family nests, away from the familiar branches of their own trees and the company of their own brothers, sisters, nephews and neighbours. The busy storks soon filled each multistorey hospital nest, while more and more of the healthy foragers were drawn in to labour for the reluctant cuckoos. Soon all the nests of the wood were commandeered and the eggs thrown out of them to make space for more old cuckoos.

It came to pass that the hard-worked and healthy birds fell ill from fatigue or suffered accidents or injury, but so successful had the enlightened Mr. Starling become that there was no time nor space nor workers left over to care for them. Their names however were promptly added to the waiting list, already many summers and winters long. But they did not worry too much because they knew that if they could hold out for a year they would qualify for Mr. Starling's new plan and be

brought in as elderly birds. No eggs hatched anymore and those that had been laid with no one to incubate them, were sent off to "advisory bureaux" where suction devices were applied to them.

And so it came about, as the labouring birds became exhausted, that the wood became sadly silent. The dawn chorus became dyspnoeic and little was heard but the occasional clatter of claudicating crows, and the flop of drooping tits. The legal eagles ceased their deliberation on who killed Cock Robin, but argued instead as to why, when he was mortally wounded, the Casualty Department was shut and the hospital nest, with equipment to save his life, was full of cuckoos? Meanwhile on the ground bewildered two-legged animals marched up and down with placards proclaiming "Green Peace" and berating each other for having perpetrated a pollution and caused such an ecological disaster.

Mr. Starling was horrified. "What have I done?" he cried, "I did what Owl told me and followed Dr. Sanshart's instruction." He went to ask Owl what he should do next but he was nowhere to be found. Some said that Owl had given up flying and was last seen walking in a different wood looking for a chair.

"Humph," said Mr. Starling for the second time, "one must beware of false prophets."

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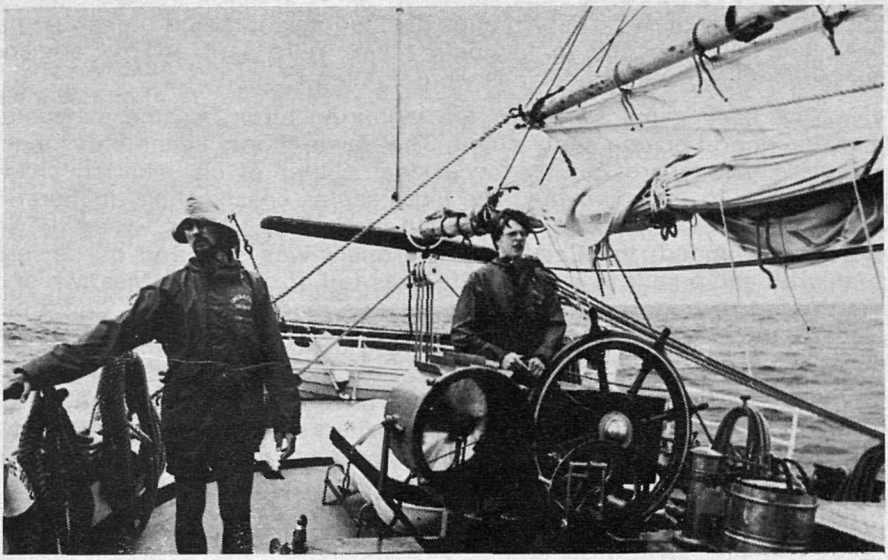
Operation Drake, 1979 (Part II)

by Adrian Penney, medical student.

The Fijians are a very warm, easy-going and forgiving race, their social graces and manners make our Western behaviour seem awkward, reserved and stylised. It was a very special chapter for us all, the spirit of which is very difficult to transpose to paper.

We now had to sail to Lae in Papua New Guinea a journey of about two and a half thousand miles. This was on the 'Eye of the Wind' a 150 ton, 132ft. hermaphrodite brigantine. Sailing a square rigger was an exciting new adventure with visits to remote islands of the Solomons and Marshall Bennett groups. These visits provided a chance to study the health and the culture of these 'deprived' societies. In addition fresh fruit was abundant and available not to mention the opportunities we had of climbing on the beautiful limestone cliffs and sailing in their outrigger canoes—which are up to about 45ft. in length. Trade wind sailing with its constant warm wind, interspersed with severe squalls but always accompanied by a large swell was a totally new and dry experience. I could almost become converted! Visiting the Guy's community in Honirarar provided an interesting insight into medicine in a developing country and I was made most welcome. Between two of the islands we were approached by a couple from San Francisco who were



Above: at the helm of 'Eye of the Wind'.

sailing round the world—they had already been sailing for five years such is the interest and uniqueness of these beautiful islands. They wanted advice on antimalarial prophylaxis and at the same time I had to give antenatal guidance. Operation Drake was always full of surprises like this.

Into the Jungle

We arrived in Lae, the commercial capital of Papua New Guinea, at dawn to be greeted by a welcoming party of war canoes and tribal dancing. It had been a memorable last night which began with a party and ended in a vicious tropical downpour which reduced visibility to less than 50 yards, such was the volume of rain. We soon began a jungle survival course in which the trials and tribulations of the Papuan jungle were soon made self evident. The dampness, humidity, steep slopes, swamps and impenetrability of the jungle were quite an eye opener for one used only to temperate conditions. We were fortunately in the dry season but it still rained most of the time!

We now had only 4 weeks left in Papua before our phase was over, the next phase Y.E.'s are to spend all their time in DNG. There were a multiplicity of projects—I chose to go into the Finisterre mountains to locate downed U.S. W.W. II planes on behalf of the U.S. War Graves Commission, and to look at the burial ledges and cave system of the Snake Valley. Other projects included the navigation of the Balolo river—white water never previously navigated; studying the Strictland gorge with a view to navigation during the next 4 months—on this recce several new tribes were discovered; the surveying of the wartime

Japanese and American trails, to assess their viability as a tourist attraction, the Wau, Bulldog, Salamoa are the main ones; diving for W.W. II wrecks; Exploration of the old gold working of the Wau valley; and of course the scientific work which was based on a camp at Buso.

Five of us went up to the Finisterres and spent the first three days involved in a sing-song to celebrate the fourth anniversary of Papua New Guinea's independence. This is the one time of the year that the hunters and people come down from the more remote villages to participate in frenzied 72 hour non-stop singing, dancing and sport competitions. Indeed there is terrific inter-village rivalry—so much is at stake

Left: festivities at the fourth anniversary celebrations.

that one village who disagreed with the judges' decision of one competition upped and offed en masse in the middle of the Saturday afternoon. However, they returned in the early hours of the following morning.

At the same time this provides an opportunity for a feast, and to this end three steers were obtained and slaughtered. Shortly after arriving and being made most welcome to participate in this ceremony

my medical connections were mentioned and I was asked to certify the animals fit to eat—the chief "butcher" was concerned about some haemorrhagic spots in the liver, kidney, gut and brain of one of the animals. Would they be safe to eat? Not being really sure what was expected of me I adopted a suitably professional and inquisitive attitude and felt almost like a pathologist as I examined the offending viscera to proclaim them quite fit for consumption, hoping at the same time that I wasn't going to kill off one third of the villagers. For my efforts we were presented with a bucket of steak, which was greatly appreciated.

Right: villagers awaiting a professional opinion on the viscera.

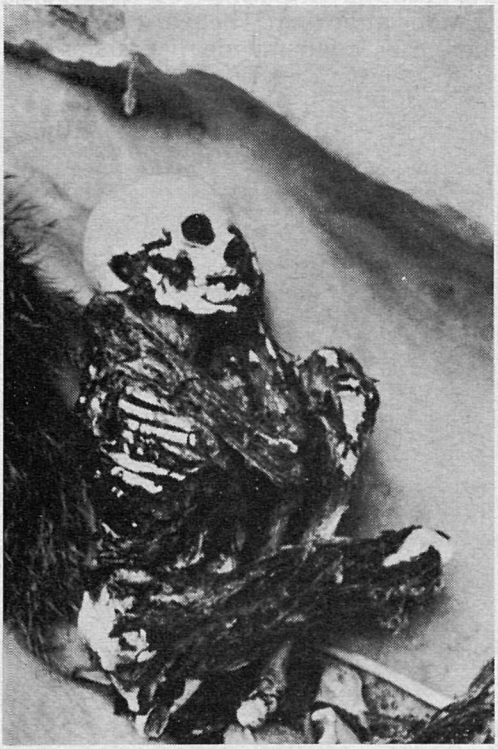
The hardest three weeks of my life now followed, living in the jungle. It was tough but great fun. We found one previously unnotified plane, a P47, but it had no human remains. To find it we used a hunter who had seen it once about three years previously. It took a week of hard climbing to get there, it was only about 12 miles from where we had made our base, such is the terrain. Unfortunately by the time we had returned, there had obviously been some discussion about what we were doing, and we were told that we could not go and see any of the other planes that we had located, the excuse being the Masselai—the black spirits of the region—which it was said would make us die. This was an introduction to the very interesting black and white magic and the concept of the Cago Cult. In the spare week I was fortunate in

being able to spend my time at the new "health centre" which is run by a Health Extension Officer (H.E.O.) a paramedic with three years training. It was a valuable introduction to tropical diseases and the killers of this region—pneumonia, meningitis and malaria.

Burial Ledges

The burial ledges of the Snake Valley were most interesting. These ledges (about 120 ft. up a vertical cliff face) are covered in assorted bones. I counted 60 complete skulls in one small area alone. The skeletons are all incomplete, the bones have been moved around. There was one body which appeared to have been smoked, an old custom which is limited to a few tribes, who would smoke and then drink the body juices to retain the spirits of the deceased.

The three and a half months passed very quickly and the experience was a most valuable one which I can but recommend and encourage anyone to take up if ever they have the slightest opportunity. Having just failed my surgery finals it was to have been a break from medicine, but in fact I ended up having more responsibility and far more to do medically then ever before!



Above: the smoked body on the burial ledge.

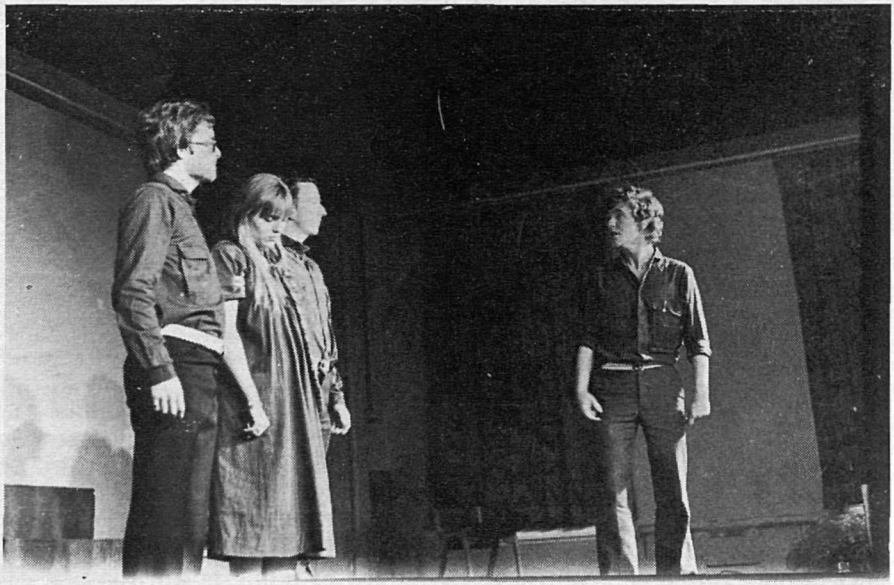
Antigone–Guy's Hospital Theatre Club

by Mark Powlson

The Theatre Club has, over the last year, re-established itself with highly commendable industry, with the aid of a considerable intake of "new" talent. Several highly acclaimed short productions in recent months culminated in the production of a longer, and more difficult play —which had to be held in the relatively circumscribed conditions of the Ballroom.

The play performed was Anouilh's *Antigone,* in a new translation by Mr. Mark Owen. This was the most idiomatic English translation of the work that I have yet seen (I seem to recollect two others), and the success of the production owes a great deal to it. The director, Keith Lloyd, made the most of this good choice—emphasising the dialogue by eschewing lavish scenery, by some telling stage direction, and by eliciting some fine performances from his actors.

The story of Antigone is well known—Anouilh adapted it from Sophocles, who had in turn adapted a well-known Greek story. The heroine, daughter of the ill-fated Oedipus, defies her uncle Creon, now king of Thebes, and resolves to bury her traitor brother, Polyneices, who has been slain while attacking Thebes. The drab Antigone partly succeeds, and then tries to persuade her sister Ismene (vivaciously played by Hélène de Peloux Menagé) to help her complete the funeral rites. When Ismene refuses horrified, she tries on her own, but is caught by the guards and taken to Creon. The confrontation is the crux of the



Above: Antigone caught by the guards.

play, and it was in this most telling part that acting, translation, and direction achieved their peak, resulting in a remarkable dramatic tension which was maintained for the rest of the play.

A fine performance by Imogen Tucker illustrated the dichotomy of Antigone's character—that of an apparently uninteresting, uninterested person who nevertheless has the fervour and internal commitment to defy Creon and be faced with death. Her misplaced idolatry of her elder brothers is smashed by Creon—who proves to her that they were wastrel ingrates—but, after faltering, eventually persists in following her own beliefs of humanity. Even this performance, however, was overshadowed by Tim Lancaster's excellent portrayal of Creon. Looking the image of a modern politician, he almost succeeds in convincing Antigone, both by reason, and by showing his personal compassion for her "misunderstanding", and his readiness to forgive.

Yet Antigone finally decides to ignore Creon's reasoning, and to follow the dictates of her heart—not reason ("Yes, I speak with my father's voice"). It is here that her humanity asserts itself, and where Creon (who hitherto might have seemed the more reasonable) reveals his basic misconception—that human, personal beliefs should be subjugated to those which are "good for the state". Despite the pleas of Haemon, his son who is engaged to Antigone, he sentences her to be immured in a rock-hewn chamber. It was here that Haemon (Neil Deuchar) was most convincing, showing the destruction of his image of a benevolent, reasonable father.

Creon confronts Antigone.

Photos: Simon Harley.

The two excellent central performances, and the fine portrayals of Haemon and Ismene were aided by the clarity of the Chorus (Greg Halse) in the continuity, and by a good performance by Andy Emerson

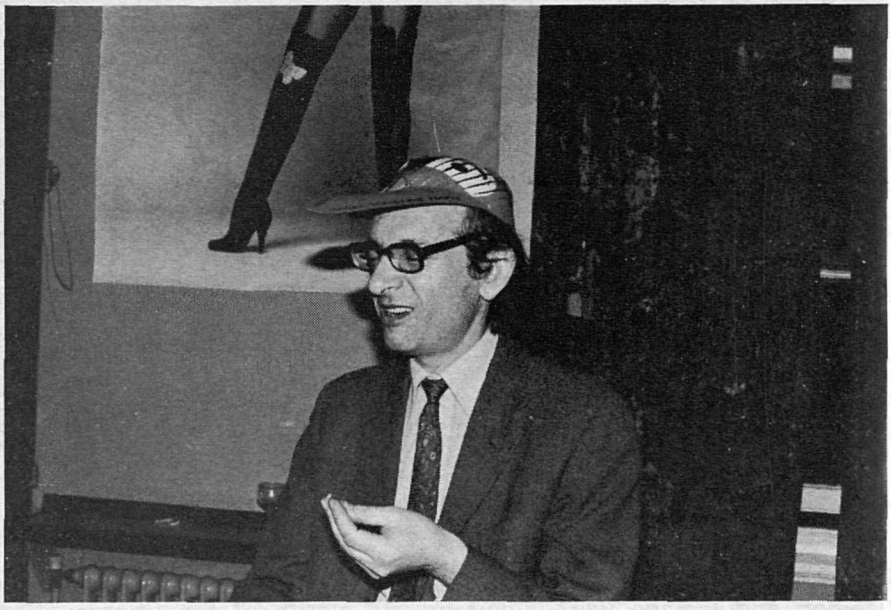
as Guard Jonas. The smaller parts were also realistically played, despite less material. The lighting (by Jeremy Weinbren) was well managed, and the few sound effects by Wilf Treasure were telling.

This performance of *Antigone* was very gripping—especially during and after the Creon/Antigone confrontation—and was a triumph for those concerned, and for the Theatre Club. Such an array of talent bodes well for the future of the club, and the large audiences seen here, and at other recent smaller productions, would indicate that the Theatre Club has again built up a considerable following in the hospital.

Report of the Senior B.M.S. party

by Tim Lancaster, medical student

What a pleasant event the B.M.S. party is—the one occasion when the strange mélange of academics, students and technicians which makes up a medical school suddenly seems to make sense through the filter of a submarine alcoholic haze. And with the added bonus of being able to make peace with all those teachers whose tutorials you've been missing all term!—amazing how these things appear in their correct perspective in the glow induced by good food and drink, and genial repartee.



Above: Dr. Tammar in festive mood.

It was interesting to see in which departments the epicurean strain ran deepest. Biochemists were there in force—no surprise to those of us who know them well. The Physiology department also turned out in impressive numbers, some with spouses, and led by Professor Macdonald, whose reputation as a slim-line ascetic took a beating when he accepted not one but two pieces of cheesecake: think of the blood glucose! Most under-represented were the Anatomists, with only the irrepressible Professor Joseph carrying the colours. Perhaps they felt inhibited in the absence of hedonist Mike Hutchinson, who was unable to fly back from Chicago for the event. A large proportion of the Pharmacologists appeared to be away attending conferences in exotic parts, though those present were in fine form. One of them confided that he always felt he could safely come to the party, as the revue never took him off: wait till next year, Bryan.

The Ballroom, decorated by Dave Edwards and his team, was looking in festive mood, and it was clear from the outset that everyone was going to enjoy themselves. After a few (!) drinks, the food, superbly prepared by any number of galloping Guy's gourmets, and organised by Sarah Dawson-Edwardes, appeared as if by magic, and more surprisingly continued to appear throughout the evening, despite the efforts of some of those present to break the world record for mince-pie eating.

When the mood seemed suitably forgiving, the revue was announced—undoubtedly the most nerve-wracking part of the evening for those taking part. Alternating fairly evenly between music and straight sketches, the show started with a mythical interview for entry to Guy's: the candidate, an erstwhile cookery student, was finally admitted on the strength of his avowed interest in bestiality. The amazing fingers of Wilf Treasure then launched into his version of the B.M.S. blues ("wrote this verse during a lecture, well the words are bad, but the lecture sure was worse"). Peter Jolliffe, complete with greying wig and B.O.A.C. carrier bag gave us a penetrating impersonation of a well-known Scottish member of the Pharmacology Department, ably supported by a tutorial group who were painfully realistic. A version of *Waltzing Matilda* sang the praises of Australian (or is he a New Zealander) Ray Cash—pity they couldn't have incorporated a reference to the striking Antipodean check suit which he was sporting on the evening itself. Talking of distinctive clothing, Jeremy Weinbren was instantly recognisable in the next sketch as he arrived wearing a pair of sandals, which those of us with an interest in muscular dystrophy recognised straight away. His monologue "a rendition of your favourite biochemical phenomenon", was undoubtedly one of the highlights of the evening ("In Stockholm I met Eccles, Eccles, Eccles, Eccles and Eccles, the well-known schizophrenic"). A medical viva set to music à la Gloria Gaynor was stylishly put across by Sarah Evans in a vampish mood.

The final sketch of the evening involved the author of this piece in an impersonation of an infamous professor who shall remain nameless: the impersonator (not alone among the cast) had to get so drunk to carry this one off that he fell, rather ignominiously, from the stage in full flow—lucky that lecture theatre go up, not down. Thanks to Graham Zaki for co-ordinating the show, and to Andy Emerson, Peter Jolliffe and Dave Edwards who did most of the writing. I suppose it's just as well

Above: Jeremy Weinbren as Dr. Watts.

these things only work one way: the prospect of lecturers taking off their pupils could be quite awesome—*not the nine o'clock lecture* perhaps?

The evening continued till the small hours under the expert disc-jockeying of Ian Renwick and co., and staff/student relationships seemed to get better and better as the night went on! Pity the animals had to start misbehaving towards the end: no one really minds crashers, but it's a little sickening when they start throwing around ham rolls that someone has bothered to make in the first place, and someone else will have to clear up.

Finally, congratulations to Chris Donovan, who as the principal organiser was one of the main reasons for the success of the evening.

Beyond Jogging

by Maurice Yaffé, Senior Clinical Psychologist, Guy's Hospital

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The pursuit of physical fitness is the new religion, and involvement in sport its present-day apotheosis. The current renaissance of interest in physical health is reflected by several nationwide campaigns, such as that of the Health Education Council for a fitter Britain, entitled Look After Yourself; this is to be closely followed by a separate keep fit campaign in Scotland. Interesting that the HEC incentives include, amongst other things, a better sex life to those who follow their direc-

tions. But despite the long overdue schemes to encourage people to establish a healthier life-style, the Sports Council has had to abandon their 1979 national fitness campaign, Feeling Great, due in part to their being pre-empted by HEC.

It is only ten years since Dr. Kenneth Cooper, as USAF medical officer, published his pioneering book *Aerobics*, which was to change a nation's outlook towards physical fitness. Aerobics, according to Cooper, refers to a variety of exercises that stimulate heart and lung activity for a time period sufficiently long to produce beneficial changes in the body; running, swimming and cycling are typical aerobic exercises. The basic idea is that by making one work hard, the demand for oxygen is increased, which is the main aim of an aerobic exercise programme. The more oxygen the body can process within a given time (the aerobic capacity), the better; this is dependent upon an ability to rapidly breathe large amounts of air, forcefully deliver large volumes of blood, and effectively deliver oxygen to all parts of the body. The aerobic capacity, reflecting the efficiency of the lungs, the power of the heart, and the state of the vascular system, is the best single index to overall physical fitness.

Based on data from a large sample of American civilian and military personnel, Cooper developed an age-related points system which allows individuals to obtain the precise amount of exercise necessary for their specific needs. Last year's *Which?* report on How to Get Fit attempted to do this in more general terms; exercises were divided into three types (endurance, suppleness, and strength), and information was given as to what type(s) of exercise various activities tap. In a survey initiated in 1968 by the Medical Research Council it was found that those who take vigorous exercise for at least one hour a week are about a third less likely to develop coronary heart disease. Those who go in for mild exercise seem to do no better than those who claimed to take little or no exercise. This is one of the problems of the jogger: in deliberately running slowly he does nothing to increase his aerobic capacity.

Another is the competitive element, which is even creeping into the practice of jogging—no one wants to be last, even in a *Sunday Times* Fun Run. It may seem surprising, but the close and, to all appearances, inevitable relationship between sport and competition is of fairly recent origin—ever since the last quarter of the nineteenth century, when sport started to be taken much more seriously. The rules have become more and more rigorous and elaborate. According to Johan Huizinga, the author of *Homo Ludens*, the increasing systematization and regimentation of sport has led to the inevitable loss of its pure play-quality. The official distinction between amateurs and professionals exemplifies this: amateurs feel inferior to professionals for whom financial commitments are totally binding.

Because of the prevailing win-at-all-costs philosophy, sport no longer represents the play-element in our society; nor is it any more part of the cultural process. In ancient cultures the great competitions were always part of the sacred festivals and necessary as health-and-happiness-bringing activities. Many civilizations recognised a profound connection between sport, philosophy and religion. The relationship between games and the holy, between body and spirit, has been cele-

brated for millenia—in the original Greek Olympiad, in the Irish sacred games, and in the rituals of Tibet, like the *lung gom* walks in which a monk expressed his mastery of the inner life by walking for thousands of miles without stopping, in the Mayan ballgame, and the martial arts of China, Korea, and Japan. In modern times, however, most of the connection has been lost; religious games have vanished in the secular West.

But a new wind is blowing; this time from California. In the past few years there has been a move to re-establish the connections between sport, psychological well-being, and aesthetic values. An increased appreciation of the beautifully executed play and of the elegant move reflects, in part, this concern—the instant slow-motion replay has, of course, brought it to the foreground and made it much more accessible.

In the spirit of these developments several texts have appeared where inner mental states are highlighted as the key to optimal performance, the ultimate goal being the nirvana-like "peak experience". This is the sport equivalent of orgasm; it, not surprisingly, happens rarely to the unskilled, who make many unforced errors most of the time, but when it does, strokes and movements occur effortlessly and spontaneously. It is accompanied by an intense feeling of enjoyment or ecstasy.

One such approach is that of transcendental meditation; this has been investigated in relation to running speed, jumping ability, agility, heart rate, and breath volume, and the improved responses using TM look encouraging. Several intriguing books and articles deal with the Zen Buddhist introspective approach to sport and include accounts of jogging, tennis, golf, frisbee throwing, archery, and even skateboarding. Their essential contribution lies in the fact that sport is used as a vehicle to change one's outlook on life, and to help a person learn the art of relaxed concentration, rather than simply to beat one's opponent. To take jogging as an example, it is amazing how many people run the same distance at the same pace for months on end. Whether they gallop or trot, few actually appear to enjoy themselves. According to one authority in the United States at least a third of these runners could improve more quickly and enjoy running more if they knew a variety of gaits and tempos; in this context running is seen as an art form as well as a means of physical conditioning. Visualization, meditation and self-awareness training are used to bring new insight into the activity.

Obsessional people play sport obsessionally. These techniques allow for the possibility of change. To quote George Leonard (from *The Ultimate Athlete):*

> *"In every fat man the saying goes, there is a thin man struggling to get out. If this is so, then every skinny man must at times find himself surrounded by the ghostly outlines of muscle and heft. And there must somehow exist an ideal physique for every one of us—man, woman and child. Everyone that moves, about this planet, if you look at it that way, may well be inhabited by a strong and graceful athlete capable of Olympian feats."*

Clearly the search for our inner athlete goes beyond physical fitness. The quest for self-expression through the body has just begun.

Nursing

The following quotations from Emily MacManus's book "Matron of Guy's" are about Christmas 1911.

". . . Then up went the ward decorations, followed by a special tea for patients, nurses, students and other helpers. Each ward had a scheme and became transformed—Old Japan, A Summer Garden, Advertisements, Sports, Quotations;" "About 5 a.m. [on Christmas Day] an enthusiastic band of carol singers from the Nurses' Home made a tour of the hospital. With their cloaks turned inside out to show the scarlet lining, their white caps and aprons, and their winking lanterns carried on sticks, they made a picture." "After the patients were served and the debris cleared away and washed up, all the ward staff, sisters, doctors, nurses and any students who remained—generally the 'take-in' firms—sat down to a cheery meal together."

Almost seventy years later there are no lanterns on sticks or aprons, but otherwise the passage could be describing a present day Christmas at Guy's.

However there are some Sisters who while observing the traditions, sadly do not seem to think that the spirit behind them is important. The feeling of a ward at any time depends very much on the Sister's attitudes, and above all it is important that she is there at special times. It is sad to hear of Sisters who want to take holiday at Christmas. It also seems a pity that Christmas ward closures are not discussed with the Sisters so that those who wanted or needed to be away could have their wards shut instead of those who wanted to stay often having to move to another ward. Evidently the people who decide such things also consider that the way the ward is run at Christmas is unimportant.

For those who have never experienced a Christmas in hospital, I had better try and explain what is special about it. Everyone knows that Christmas is a time of bonhomie and good cheer, and in a ward where patients are still ill and people still have to work this produces a sense of unity and comradeship. This is why such traditions as the ward decorations are important—because everybody is working together to make things as happy as possible for the patients who have to be there. It is a good thing to be reminded now and then that this is actually what we are trying to do all the time. It is also important that all the staff have tea, and Christmas Dinner, and a glass of sherry now and then, together. Everyone relaxes a little—Sister who is usually so terrifying seems quite human after all, and that snooty houseman is really quite friendly.

In 1979 these traditions are more important than ever. In any ward the pace is fast and everyone works under a certain amount of pressure. A happy and relaxed Christmas during which the Senior staff have shown that they care about the wellbeing of the Juniors will do much to improve morale, and this of course benefits the patients. Perhaps the lesson to be learned is that we could do with a bit more Christmas spirit throughout the year.

JULIA FABRICIUS.

Book Reviews

"Local Analgesia", by Jolly, 2nd Edition. Pp. 152. Price £5.00. Published by H. K. Lewis.

There has been a renewed interest in local analgesia in recent years, due mainly to the foundation of clinics to deal with patients with chronic pain. The application of nerve blocks in the treatment of certain types of chronic pain can be most effective. The appearance of the second edition of this book, after seventeen years, will be welcome since it fills the gap between the brief sections on local analgesia in the standard anaesthetic text books and the more extensive books devoted solely to local analgesia. The latter are inevitably expensive because of the large number of diagrams and drawings necessary to make the text fully comprehensible.

This book deals with all the commonly used nerve blocks. It is clearly written and has a wealth of practical information. One criticism might well be that there are insufficient drawings to make the more difficult blocks understood, but to do this and keep the price down would be impossible. However there is no substitute for direct reference to dissections and the skeleton, and the author clearly intended that these references should be made.

There is a useful chapter on the various local anaesthetics, and a brief chapter is devoted to the management of certain types of chronic pain. This is only intended as an indication of the possible use of local techniques, and for those readers interested in a wider application, a list of books for further reading is included.

I was disappointed that no mention was made of the inter-scalene approach to the brachial plexus, and that nerve block at the ankle was considered too much of an academic exercise, since both blocks are of value. There were three printing errors which could be misleading: First on page 37, it is recommended that a 1.5 cm needle be used for a stellate ganglion block. This would be too short in most instances. Secondly on page 77, "Seventy mgs. of absolute alcohol" and "five mgs. of 0.5% bupivacaine" should read "Seventy mls" and "five mls" respectively. Thirdly on page 109 in describing the epidural space it is stated that "The dura is attached to the margins of the foramen magnum superiorly and inferiorly the space is closed by the sacro-coccygeal ligament at the level of the second sacral vertebra". It is of course the dura which terminates at the second sacral vertebra and not the epidural space.

Overall this is a most useful book, and will be of value to any doctor interested in providing local analgesia.

J. HELLEWELL,
Consultant Anaesthetist.

"Local Analgesia in Dentistry", by D. H. Roberts and J. H. Sowray, 2nd edition. Pp. 155. Price £9. Published by John Wright.

Local analgesics (anaesthetics) must be among the most widely used drugs in this country with the bulk being deployed in dental surgeries.

Their safety is implied by the lack of anecdotal evidence of toxicity (have you ever met anyone who has seen a drug-related side effect?) and confirmed by the statistics of the committee on Safety of Medicines. In 15 years reported side-effects (of lignocaine) were 348, even allowing for considerable under-reporting that is a good record.

In some measure this must be due to the first edition of this book which was so well received and widely used. The second edition has all the excellent features of the first and is brought right up-to-date.

I have only one or two reservations:

(a) The last chapter on dental hypersensitivity is out of place (it was in the first edition and I am surprised that it is still there).

(b) It would be nice to have a little more background sketched in on the use of local analgesics in other disciplines, i.e. spinals, epidurals and intravenous local analgesia and the control of cardiac dysrhythmias.

(c) With sedation assuming ever-increasing importance as an adjunct to local analgesics I would have liked to see more emphasis on this (with a good deal less space devoted to the outmoded Jorgensen technique).

(d) Finally, in this text aspiration before injection is uncritically accepted as necessary. In dental practice there seems to be absolutely no evidence that aspiration reduces the incidence of side effects, so emphatic support for the practice may be misplaced. (Jet injectors do not allow aspiration but they seem to be creeping in.)

In conclusion I will warmly recommend this book as practical, helpful, reliable and comprehensive.

R. HASKELL,
Consultant Dental Surgeon.

"Venereology and Genito-urinary Medicine", by R. D. Cotterall. Pp. 211. Price £3.25. Published by Hodder & Stoughton.

The word "Venereal" is a thoroughly bad term for clinical use, as most thinking people now realise; but this should not detract from a useful book by an experienced physician.

The work covers the inflammations, infections and assorted lesions of the genito-urinary area which come to the notice of practitioners dealing with patients where sexual intercourse is a factor in the situation.

This book can be read with advantage by anyone interested in the subject, whether they be in a nursing discipline or a medical one.

A. S. GRIMBLE, M.D., F.R.C.P.
Dept. Genito Urinary Medicine

"Anatomy and Physiology for Nurses", 9th edition, by Sheila Jackson. Price £2.25. Nurses' Aid series. Published by Ballière Tindall.

This is a text book on basic anatomy and physiology. It is small, compact and profusely illustrated. There could with advantage have been a little more emphasis on the physiology and less on the anatomy. It is difficult to know which nurses today need to have such detailed knowledge of bones, joints and blood vessels, whereas they might well need to understand more about immune responses. It might also be more helpful to nurses if the physiology discussed was in relation to actual treatment or care, so that knowledge of physiology seemed to be linked to an understanding of care. This little book has been in print for many years; it deserves to be brought up-to-date.

B. B. WHYTE,
Director of Nurse Education.

"First Level General Nursing", by P. M. Burrowes and M. Reakes. Pp. 205. Price £3.75.

"Nursing Theory and Practice", by J. Bickerton, A. C. M. Sampson and A. Boylan. Pp. 231. Price £3.95.

"The Profession of Nursing", by R. Hoy and J. Robbins. Pp. 166. Price £3.50.

These three texts are published by McGraw Hill and form part of a comprehensive approach to the provision of nursing text books. The series was planned as an adjunct to the teaching of the syllabus envisaged in the Briggs Report (1970). All three books are beautifully produced, with clear text and excellent illustrations. They are all extremely pleasant to read and handle, the difficulty is in deciding for whom they are each intended.

First Level General Nursing

It is assumed that this is meant as a textbook for any nurse during the first eighteen months of her training. The chapter headings seem sensible—nursing patients with cardiovascular dysfunction; nursing patients with problems of breathing, etc., so it is a little disconcerting to find that the content of the chapters is a brief review of different conditions. For example, in the chapter concerned with difficulty in breathing, carcinoma of the lung, pneumonia, asthma and other conditions are dealt with rather than the principles of care of that particular symptom. There are, however, chapters on such subjects as "tissue response to injury" which are of a general nature. The last section deals with care of patients in differing age groups, or with specific conditions such as infectious diseases. The discussion on the care of the individual patient is sound, and the description of the problems of patients with (for example) colostomy are excellent. It is perhaps a pity that in this day of teaching nurses to consider the needs of each patient as an individual, this book should have adhered so closely to the medical model.

Nursing, Theory and Practice

The five sections of this book deal with "the nursing process": "The physical make-up of the patient"; "The psychological make-up of the patient"; "Nursing Care" and "The nurse and the mentally ill". The section on physiology is very good, although it is in no way linked with nursing care. There is a great deal of repetition of information, as the chapter on understanding the

patient's needs restates a great deal already set out in the chapter on the psychological make-up of the patient. Looking at the chapter headings it appears that the patient's mind and body are still considered as separate entities, although I am sure this was not what the authors intended. There is a great deal of excellent material in this book; it is a pity that its presentation is so confusing.

The Profession of Nursing

It is not very clear for whom this book is intended, but it contains some interesting material. The chapters on the nurse as counsellor are good and could have been expanded. The chapter on research is good and could have formed the basis of a separate text book.

In short, all three volumes seem to represent a laudable attempt to look at nursing in a new way, which has gone a long way to getting away from the old pattern, but has not gone nearly far enough. It would be a good idea to put them into libraries of nursing, because they contain much new material, but they have not quite caught up with the present teaching of basic nursing care on the patient's needs.

B. B. WHYTE,
Director of Nurse Education.

"Scott: An Aid To Clinical Surgery", revised by H. A. G. Dudley. Pp. 268. Price £4.95. Published by Churchill Livingstone.

Every mountain hut belonging to the Swiss Alpine Club contains a tin of food to use in emergencies only, labelled Unschmeckbares Essen—"un-nice tasting food". Although nutritious, the food contains only the essential ingredients necessary to prevent starvation and the taste deters all but the desperate. It is in something of this light that a group of surgical texts may be viewed which are aimed at the pre-finals undergraduates. Professor Dudley's revision of Scott's textbook is the latest of these, and may claim to be one of the less unpalatable. The book, printed in soft covers in Octavo size, 268 pages with line drawings, retails at £4.95 and covers most of the ground required for the final B.S. candidate in addition to providing some useful, though occasionally unreliable, reading for the post-graduate.

The chapter headings are admirably chosen both from the point of view of clinical relevance and examination-passing, although the cross reference system sometimes breaks down—viz. the relegation of incisional hernias to a non-existent part of the discussion on post-operative complications. There are some daunting lists, and in my view insufficient attention is paid to the concept of relative probabilities in diagnosis.

It is particularly pleasing, however, to see a chapter devoted to pain and one dealing with back ache, although the treatment of terminal pain is a sad omission. The chapter on burns is inadequate: in a book of this size a subject must be dealt with briskly and dogmatically or not at all. A chapter on lymphoma and diagnostic splenectomy would not be out of place.

Nevertheless, despite some odd ideas —like sending off a CEA on a patient presenting in the Emergency Room with an obstructed colon—this book represents good value in last minute revision. The prompt learning of its contents combined with some basic reading in ENT, opthalmology and orthopaedics may be recommended to those undergraduates who, possibly having been seduced from the traditional study of the sick in the wards by the charm of the abstruse, face their surgical examiners unprepared.

T. K. DAY,
Urological Registrar

"Accident Surgery and Orthopaedics for Students", by Pearson & Austin, 2nd edition. Pp. 441. Price £8.75. Published by Lloyd Luke, 1979.

The teaching of orthopaedics to undergraduates has become a speciality. Most surgeons are forced to graft some teaching on to their already busy clinical programme but a few take it seriously enough to divert valuable time to pure teaching. The problem peculiar to orthopaedics is that it is a postgraduate speciality, thus the surgeon is teaching a subject in which he has no training—*undergraduate orthopaedics*. Those who become undergraduate orthopaedic specialists have to learn the subject first. The subject may be defined as orthopaedics for the general practitioner and the casualty officer. This book is written both for the teacher and the taught. The orthopaedic surgeon may use it to find the level at which he should aim his teaching. The undergraduate will find discussion on those subjects he is expected to know something about.

The book follows the conventional sequence of orthopaedic disorders and is well-indexed. It is possible to find the section on most disorders reasonably

quickly. The style is dogmatic and unambiguous. Undergraduates in a hurry before finals may find the book very useful, for they want black and white answers to grey questions quickly. I am sure, however, that most will find the book irritating as a work of reference during their orthopaedic course for the very same reason. Discussion is cursory and in places contemptuous. The recent changes in our attitudes to many conditions are not given due weight and are ignored in many instances. The book should be used as a pathfinder in conjunction with a more authoritative work of reference and as such I recommend it.

MICHAEL WATSON,
Consultant Orthopaedic Surgeon

"MCQs in Anatomy", by P. S. P. Lumley, J. L. Craven and J. T. Aitken Pp. 231. Price £2.95. Published by Churchill Livingstone, 1979.

Perhaps the reviewer should not be the author of a book on MCQs in Anatomy but having declared my interest, I think I can now review this book. The introduction discusses the pros and cons of some methods of examination and indicates how to set and evaluate multiple choice questions. There follow sections on the anatomy of the body the usual headings thorax, abdomen etc. and embryology, the central nervous system and the structure of the body are included. The number of questions in each section varies from 20 to 50 and each question has 4 parts. The questions are on the left hand page with the answers and comments on the right.

I read a considerable number of the questions and came to the conclusion that the book could be recommended as a method of self-examination. Most of the questions are what a student is likely to be asked in either an MCQ or oral examination.

Almost every page however produced nagging doubts such as the statement that exocrine glands are in stratified squamous epithelium (Q.3); the use of the word prominent (Q.4); the blastocyst is a central cavity (Q.22); the pleura develops from the splanchnopleuric mesoderm (parietal pleura?) (Q.4); indirect connections are accepted as true (Q.90) and as false (Q.92); the abdominal aorta ends anterior to the 4th lumbar vertebra (to the left?) (Q.106); the deltoid is not a unipennate muscle (is the whole deltoid multipennate?) (Q.137); the latissimus dorsi is attached to the lumbar and sacral vertebral spines (directly?) (Q.138); the axis of pronation and supination is between the centres of the radial head and the ulnar styloid process (Q.155); the lower end of the tibia extends beyond the fibula (in all directions?) (Q.206); the thyro-arytenoid muscles do not adduct the vocal folds (Q.293).

I raise these points as examples of deviations from the introduction which states that "the key (the correct option or options) must be wholly correct and unambiguous." I know that it is difficult to get all MCQs just right. Perhaps some changes could be made for the reprint or next edition.

J. JOSEPH,
Professor of Anatomy.

"The Normal Child" by Illingworth, 7th Edition, Pp. 353. Price £9.00. Published by Churchill Livingstone.

In the understanding and teaching of paediatrics the precise definition of normality is often elusive. In the practice of paediatrics the clear distinction between normal and abnormal is frequently lost in a surge of interest in early investigation and diagnosis.

We recognize that a sound knowledge of the basic sciences is necessary for the study of medicine. Unfortunately however, it is still rare to find that the study of health has a place in the medical student's curriculum. The student of medicine frequently suffers from an interest in the unusual rather than the commonplace, the rarity rather than the important and in cases of, rather than persons and people.

Professor Illingworth's book reminds the reader how important it is to be thoroughly conversant with the normal variations not amounting to disease, especially when talking to parents. His book describes problems other than disease which arise in the normal child in the first three years of life. Although not a handbook of child management it offers, through the lucidity of its chapters, much to the person who counsels and advises parents.

There are few textbooks that do not date over a period of twenty-five years; this is one. It is difficult to find another book that covers the common conditions of paediatrics as well as this one.

The seventh edition has been well revised and retains all the qualities which were attained when first written a generation ago. It should be read by

every medical student, and read again by every community physician, general practitioner and health visitor.

RICHARD S. TROMPETER,
Lecturer in Paediatrics.

"Mnemonics and Tactics in Surgery and Medicine", by John J. Shipman. Pp. 302. Price £4.50. Published by Lloyd-Luke Ltd.

This pocket-sized book is dedicated by the author to "all long-suffering students" and he is to be congratulated on the ingenious way he has constructed his mnemonics. However, having looked through it, I fear that long-suffering students may continue to suffer. If anyone is capable of remembering what: "ASHAMED TO BARGAIN" stands for relative to the effects of hydrocortisone; "PASSING DUTCH CUPS" for the causes of retention of urine; "EACH PHASE OF MASOCHISM" for causes of syncope and not confuse "A E I O U" for obstetric causes of diffuse disseminated coagulation with the causes of leucopenia with relative lymphocytosis, then I suspect that person will not need mnemonics to pass his exams. Nevertheless, having said that, most people will probably find a few mnemonics in this 302 page manual to act as aide-memoires, although £4.50 may be quite a lot to pay for this.

TAK LEE,
Medical Registrar.

"The Faber Pocket Medical Dictionary", by Forsythe. Pp. 414. Price £1.30. Published by Faber.

This dictionary really would fit into a pocket, albeit a large one. Its appearance in a third edition reflects its considerable popularity among nurses and paramedical workers but presumably also among interested laymen. It does more than explain the meaning and use of words, and a proportion of mini-encyclopaedia entries allow the reader to learn the basis of electrocardiography, glean the incubation time and the clinical features of measles, and consider the implications of rubella for women of child-bearing age. These ventures into a slightly more expansive style are well chosen. An appendix on drugs, while warning against the 'do-it-yourself' approach, gives a useful introduction to the different types of drug in common use. Further appendices on blood chemistry, diet and first aid enhance the book's attractiveness.

MAURICE LESSOF,
Professor of Medicine.

Correspondence

Full Circle?

Sirs,

The trouble with the debate on Logical Positivism is that one cannot cry "Stop" or "Enough" without opening a whole new correspondence.

Yours faithfully,

JONATHAN E. M. FOX.

P.S. Would my contemporaries please stop regaling us with their fecundity—Williamson, Farrell, etc. Judith and I are working far too hard and long out here to enjoy such pleasures.

May we take this opportunity to wish all our friends, fecund and not so, all the current Season's Greetings.

J. E. M. F.

H.M.S. Tamar,
Hong Kong,
B.F.P.O. 1.
8th November, 1979.

Logical Positivism

Sirs,

What a pity that, in his haste to prove me wrong, Mr. John Pini should have misquoted himself. His original proposition read, "All bachelors are unmarried men". This has become, "All unmarried men are bachelors." But let it pass.

As Voltaire said, "If you wish to discuss me you must first define your terms." Now if Mr. Pini and other students of the process of reasoning (i.e. logic) wish to devise a private language of their own with symbols with which only they are familiar that is entirely a matter for them. The rest of us will continue to make do with ordinary, sometimes called plain, English. To me the statement, "All bachelors are unmarried men," remains an absurdity and if we reach a position in which one

variety of English needs to be explained in terms of another the result will be confusion, not clarity. Although philosophy and logic can never be made easy there is no need to make esoteric mysteries of them and in so doing Mr. Pini does them a grave disservice.

Yours faithfully,

ARTHUR H. STOCKER.

44 Golders Gardens,
London,
NW11 9BU

Terminal Care—What are the Options?

Sirs,

It was a pleasure to read the article by Mr. Mark Stringer (*Gazette*, October 1979) with its carefully researched and well documented findings. Looking back over 45 years, mostly spent in general practice, I am sure that his conclusions are sound and that time spent on study of this subject is well worth while.

It is to be hoped that the quotation in his fourth paragraph is now out of date and that present day clinicians qualify the statement "there is nothing more to be done" by adding the word "curative" and the information that the support of a terminal care regime comes next.

Yours faithfully,

CHARLES MARSHALL
(qualified 1926).

"Cranham",
18a Church Hall,
Pinhoe, Exeter,
EX4 9JQ

Beaumont-cum-Moze

Sirs,

It was with astonishment that I read the article by G. R. M. Mote (September, p. 372) on Beaumont-cum-Moze, as I was about to write to the *Gazette* on the same article!

Through keeping a sailing boat on the Walton Creeks, at the Titmarsh Marina, not far away, I too had found the stones of London Bridge at Beaumont Quay, and just a few weeks ago, the plaque on the cottage at Landermore Creek where Sir William Gull lived. I was unable to establish the nature of the connection with Guy's, as the plaque now at Beaumont Quay about the building of the quay is now partially illegible.

Please send this note on to Mr. Mote, and I would be interested to know how he came across these Guy's connections, was it also through sailing in the area?

Yours sincerely,

ROBIN POSTON

Department of Pathology,
Guy's Hospital Medical School,
London Bridge, SE1 9RT

Alpha . . . ad Omega

Dear Sirs,

It is surely good for the ego to have our scientific endeavours magically recorded in the *Gazette*. But your readers may have been slightly disconcerted to learn that some of us are turning our attention to "creative kinase". Are the bastions of Genesis at last being scaled within the deepest recesses of the Medical School? Whilst modestly acknowledging that Biochemistry has a talent-packed department we must, alas!, admit that our research is still firmly tied to earthly matters. This report may, however, shed light on one mysterious activity of our colleagues in Clinical Chemistry. Since their transfer to an extensively automatic system of analysis it has become not unknown to hear the clinician enquire "what does the vicar say today?" (a fairly unsubtle pun on the name of the system's manufacturer). We now have an equally unsubtle explanation of why, on the other hand, a plasma CPK still requires the undivided attention of an Abbott, presumably . . . just in case Guy's Hospital *Gazette* was right after all-

At the other end, as it were, I, in turn, was startled to read (elsewhere) an advertisement for "Terminal Transferase". "Could some enterprising manufacturer have unravelled a biochemical way of easing our path into the world beyond?" I thought. Quite the contrary —and no misprint this time. It turned out that measurement of this enzyme assists in the evaluation of lymphoblastic leukaemias. As the blurb simply explained, it incorporates "3H-dGTP into an acid insoluble oligo deoxynucleotide acceptor", which words, if uttered before a student audience would surely risk a challenge of "reference?" if not censure for molecular indecency.

Faithfully yours,

DAVID C. WATTS

Biochemistry and Chemistry Department,
Guy's Hospital Medical School,
London SE1 9RT.

Lewisham Sign-Ups

Dear Sir,

It is now over seventeen weeks since we finished our general medical firm at Lewisham Hospital. The sign-ups awarded to us have yet to be communicated to the Medical School Office. Whatever you think of the sign-up system we feel that this delay makes a mockery of any instructive value the assessments have as well as demonstrating an unacceptable degree of incompetance on the part of those responsible for this tardiness.

Yours sincerely,

M. CRAIGEN.
V. FOULGER.
C. NEWSTEAD.
G. PARRY.
P. REVELL.
M. SAMUELS.

Boland House,
Guy's Hospital,
SE1 9RT.

Ed: These have now been supplied.

"Kardex" or "Wardex"?

Sirs,

May I protest at the confounded inconveniences perpetrated by administrators under the guise of progress?

For instance take the humble "Kardex"—a stout file which reveals at a glance the disposition, name and age of ward patients. It has proved sturdy enough to withstand years of abuse and may be conveniently held in one hand.

Nursing Administration has taken it into their collective busy minds to "improve" this—the result being "Wardex". Being as large as a half-folded "Times" it is so heavy that only a wrestler could bear it in one hand. Each leaf so overlaps the other that patient's names and bed-numbers are half-obscured. It also attempts unnecessarily to reiterate much of the information held in each patient's notes. We are told that they last for years: in fact from my experience they rapidly become decrepit.

In the name of progress—may we see the return of the "Kardex".

Yours sincerely,

Dr. Andrew R. Johns,

14B St. Thomas Street,
London, S.E.1.

Snooker Club

Dear Sirs,

Would the organisers of Guy's Hospital Snooker Club please sort themselves out. On 31st October Imperial College turned up for the first U.L.U. League match which nobody knew anything about. It did not take long to obtain five very keen snooker players from the bar, three of which were not aware that the Club even existed.

It is about time that notices were displayed somewhere for all to see and for the organisers to realise there is a very keen snooker contingent at Guy's and that we could put out two five man teams twice each week without any trouble at all.

Should the secretary wish to retire due to the pressure of work or inability to obtain players then I am sure somebody will willingly take his place and run the Snooker Club as it should be run, in an organised fashion.

We shall await the Snooker Club's secretary's reply with interest.

Yours sincerely,

K. D. UNDERWOOD

For and on behalf of all Snooker players.
c/o Boland House,
Guy's Hospital, SE1 9RT.

Sport

A brief introduction precedes a relatively brief sports section this month. Whether this is because Gary Calver (your usual editor) has jealously stolen all the journalistic gems away to Bongo Land for his 10 week elective, or whether the various teams' contributors simply have not contributed, I have no idea. I have just to paste together what I can until the gallivanting Gary returns from his globetrotting.

So if there are any budding Ian Wooldridges out there who fancy themselves as potential authors of literary loquacity, let me have what you can supply.

Yours temporarily,

Charlie Tunnadine

(In hibernation in the Gazette Pigeonhole, East Wing).

P.S. My congratulations to Alex Williams, who has been elected captain of the Cricket Club, and also to Dr. John Rees, elected Vice-President, in acknowledgement of his long services to the club.

RUGBY 1st XV

Guy's 6pts, Old Merchant Taylors 10pts

Guy's missed early opportunities to go ahead by failing to convert two easy penalties. Meanwhile OMT's scored two long penalties and were lucky to have the advantage. Mike Reece gave Guy's backs punch in the centre and served as new inspiration. Early in the second half our opponents charged down a loose kick, further increasing their lead. At this stage the pack recovered some enthusiasm, no doubt benefiting from the aggression of one Gareth Parry. Late in the second half after a rousing run by Brazier, the backs linked well to put Portelly over in the corner. An encouraging performance perhaps, but no-one can deny that it should have been a win.

Parry, Gibson, Neill, Beard, Keevil, Brazier, Popplewell, Mihill, Duckworth, Leonard, Maggs, Reece, Williams, Jennings, Portelly.

Close scrutiny of the records revealed the astonishing fact that this was **Inky Neill's** 100th game for Guy's. The club is grateful for the services of this seasoned campaigner, and hopes that once he is over his present difficulties (eczema, psoriasis, xxxx—xxxx women and the price of Acapulco gold) he will resume his flourishing career.

Guys 3pts Mountain Ash 6pts

In the tradition of this match this was a dour forward battle. The "Old firm" took the lead with a penalty in the first few minutes after Guy's were penalized for offside at a ruck. Then the match was fought out up front with few attacking movements from the Welsh backs.

Guy's put themselves further behind when Parry conceded a silly penalty in front of the posts. Leonard was unlucky with several penalty shots and made one score in the second half as Guy's only reply.

Guy's fell into the trap of playing down to their opponents and not moving the ball well enough against a keen defence. It was again disappointing to suffer defeat by another narrow margin.

Parry, Rose, Neill, Keevil, Beard, Brazier, Williams, Popplewell, Duckworth, Leonard, Williams, Maggs, Reece, Jennings, Portelly.

Havant 58pts Guys 6pts

Guy's did everything wrong as usual in getting to away matches late (and changing on the bus!) and being taken cold early on. The opponents, who have a strong running side, took full advantage by scoring 4 tries in the first half and finishing the match as a contest in the first 20 minutes. A couple of long range penalties by Hackett was all Guy's could muster. The misery was compounded when Duckworth was concussed in the second half and everyone in the team just stopped tackling.

A disastrous performance with Guy's latecomers making their contribution to their own downfall. The wisest man this day was Ian Leonard, who got knocked off his pushbike in the morning and missed the trip altogether.

Parry, Rose, Popplewell, Keevil, Beard, Brazier, Williams, King, Duckworth, Bundy, Jennings, Maggs, Reece, Portelly, Hackett.

Fourth XV

v. Old Dunstonians 20/10

Score: 12pts. to 22pts.

The opposition eventually found a referee (and a whistle!) The team started well scoring early through Bill. Driven on by their captain's tongue (his first game in 2 years) some good attacking play developed and Dave Murdock scored although the opposition had meanwhile scored two converted tries. Special mention for Greg Earnshaw, Dave Greenaway (the opposition were spellbound by his knees) who had a fine try disallowed and to Chris King and others who have gone on to better things.

v. London Irish 8ths 27/10

Score 0–11pts.

We left Boland House with a full team and arrived one short but the opposition lent us a gigantic Australian who subsequently showed no love for the Irish at all. A completely changed side had little opportunity to put together anything constructive but good rucking up hill in the second half only conceded a drop goal. Special mention for Richard Dunn, captain and star of TV, radios and M. B. retakes, and Richard Flanagan—a fine example to us all, special thanks to Bob Davies (Rich played in his boots!)

v. Esher Colts 3/11

Score: 12–0

A fine result and a good team performance. Ian Redfern scored an early breakthrough try but the referee missed Denmark's blatent attempt to break the centre's fist with his nose. Richard Dunn started to take the team off the field in

protest and disgust. The team however returned with a vengeance thanks to a fine try by Mike Storey. Thanks to Tom Wilkinson for a fine comeback and to Nick Singer for helping us all to realise that a worse body than Richard Dunn's is possible.

v. *London Hospitals* 4th 10/11

Score 9pts. to 7pts.

It's always very satisfying to beat another hospital. This was a good team performance which was won by a penalty and converted try to a try and a penalty. Special thanks to Matt Kiln for dealing with 'Gnosher', a huge prop forward and to Mike Foxton for giving me my first try ever at Guy's.

L. Denmark.

LADIES' HOCKEY

Weds. 17th October vs Bart's 1st XI

Lost 0–1

The game got off to a great start with the twins twenty minutes late and the minibus driver foaming at the mouth. Add to this a last minute substitute with no kit and a first team fielding only five of its regular players—we knew we were on to a winner!

Strong turbulence on the Sidcup flyover and poor navigation was but a minor setback when we arrived to find there was no referee!

Conditions were good—the pitch didn't look like the usual disused brick works. From the start Bart's piled on the pressure. Good defensive work by Janet, Krisin and Slogger-Sîan managed to contain the onslaught until ten minutes from the end of the first half when a hard drive from their wing was smashed into our D past the flailing legs of hapless Sal Clark who until then had worked miracles.

The second half looked like going the same way until Wendy, Jane and Debbie mounted a strong, if fruitless attack on a solid Bart's defence.

All in all, we were lucky to lose by such a narrow margin against a much stronger Bart's side. But anyway, it was a nice sunny afternoon.

Team:—G.K. Sal Clark; LB Sîan Thomas, R.B. Ann Kerslake, L.H. Pippa Herod, C.H. Janet Singleton, R.H. Kristin Pagano; L.W. Wendy-Jane Stephenson, L.I. Louise Doyle, C.F. Debbie Unwins R.I. Martine Syron, R.W. Julia Kerslake.

Wednesday, 24th October

vs Royal Holloway College 1st XI

Cup Drawn 3–3

It was definitely not a nice sunny afternoon—even Sîan was subdued enough by the fog not to remark on the weather! Umpire hunting in the spit proved successful, though I gather Mr. Hett was not impressed to learn of Julian's defection to the Ladies.

Guy's began the match in fine form; the forward line looking very impressive (against an equally strong Holloway defence) and managing to dominate the first 15 minutes of the game. This pressure in attack was maintained throughout the first half but Holloway had managed to find two tiny holes in the Guy's defence (and two pretty enormous ones in the temporary goal keeper) and left the field at half time two-nil in the lead.

The second half was again Guy's dominated, the team indignant at being behind a weaker side than itself (and pretty furious with the temporary goal-keeper)

Some brilliant crosses from Wendy Jane and Ann were eventually rewarded by our first Goal, scored by Kristin—a classic Pagano goal from the back of the D. Holloway quickly replied with a third goal leaving a scoreline of 3–1 with only 15 minutes to play.

Brilliant midfield play from Debbie, equally brilliant defence by Slogger Thomas and Andrea and much abuse from the temporary goalie kept the maintained Holloway pressure under control and kept the ball out of our half and allowed further great play from the Guy's forwards. Elaine slotted away a wonderful goal to raise the morale and Judith followed suit with a spectacular (if not dangerous) shot high into the corner of the goal.

Holloway piled on the pressure from then onwards winning a series of five corners. Decisive aggressive clearances by Guy's defence and a brilliant save 3 minutes from the whistle left Guy's with a hard earned, but well deserved result of 3–3 in their first Cup match of the season.

(Team): W. J. Stevenson; Judith Bury; Kristin Pagano; Elaine Dare, Ann Lewis, Janet Singleton, Debbie Unwins, Ann Kirslake, Andrea Wansbury, Sîan Thomas, Sally Clarke.

Saturday, 27th October

vs University College Won 3–2

We left in convoy in high spirits; the sun was shining especially for Sîan and

we had a full side of ten hockey players and Helen Reece. We lost Kristin's bunch in a panic along the Holloway Road which was a shame because she missed the guided tour of Islington. We arrived early enough for a pub lunch which we left in still higher spirits.

The first half isn't going to be heavily reported—terrible umpiring prevented Guys forwards moving for obstructions and although the far stronger side the first half ended with Guys 1–0 down when they found an enormous hole in our defence (Helen Reece) and nothing between them and the goal except the G.K. and a little hole through which they cunningly put the ball.

The second half was a different tale —a new umpire (one who could see this time) allowed the play to flow and Fiona scored a brilliant goal which began with a superb pass by Julie to Kristin who crossed the ball well. Kristin scored next —from a free hit she powered a shot from the back of the D. Meanwhile back in our half so little had happened that Helen was having a nap (yes, actually lying down on the field).

Suddenly the whistle went and Guys had been awarded a penalty flick—and that's enough said about that—The score was 2–1.

Ann scored next, some skillful play getting her into a shooting position and a long hard shot to finish.

The game seemed destined to end in a 3–1 win when U.C. made a break. A brilliant tackle by Hellie on her Inner (who unfortunately wasn't the man with the ball) nearly saved the day, and Sally didn't nearly save anything.

The final score of 3–2 didn't reflect the play but anyway the trees were nice.

HOCKEY

3rd XI

The morning of Saturday, 13th October saw the birth of a new conception in Guy's hockey—a 3rd XI team. Led by a captain, Andrew Tresidder, whose selection techniques mean that, anyone whose skills surpass his own, is welcome to have a 'bash', the embryo team took on the combined might of the Physiotherapy School (minus two of their best players, so we were informed) and a lone dentist.

After a surprisingly energetic start, and a goal scored by Sukhpal Singh in a fit of brilliance, the 3rds, those with this instant glamour, slowed down to a stroll, and proceeded to let the physio's run all over them (what strange perversions are coming to light?) with the score at 3–1 to the physios', trouble loomed on the horizon with the appearance of a substitute referee, namely Peter Sanders, who, in his efforts to charm the stick whirling females, stopped the game at every possible excuse and waved his arm in the general direction of the 3rd XI goal area.

This was too much for the incensed hockey prodigies, and a vicious battle then ensued. To the sound of sticks cracking against fingers and the 3rd's goalie satisfying a bloody vendetta on the lone dentist, the 3rd XI came through in the end, assisted by a few more orbital shots from Singh and a general minimum of skill. The score rested at 4–3.

Thanks must go to Paul Upton, who let the game flow so well, and Peter Sanders who, not satisfied with winning the game for us, proceeded afterwards to shatter any remnants of Physiotherapist nervous tissue, by showing up their lack of aviation skills in the ensuing jollities. Overall, the fixture was a great success and a slap on the back for the hockey club top brass, whose brainchild is the 3rd XI.

Those who performed included:

For the physio's—Nickie Crofton, Kay Gell, Diana Wells, Clare Watts, Fenella Davies, Helen Dazeley, Julie Dinwoodie, Juliette Torrance, Clare Wheeler (capt.), Martina Syron, Hilary Pronting.

For the 3rd's—Neil Oastler, Geoff Rainer, Richard Hurell, Nick Cooke, Clive Southgate, Andy Emerson, Tony Harris, Peter Wood, Simon Harley, Stephen Adams, Sukhpal Singh, Simon Gregson, Dave Heal, James Fellows-Smith, Andrew Tresidder (capt.)

Andy Emerson.

v. Unilever 20th October Score 0–10

Having narrowly won our first match, we lost to our first visiting team, Unilever, by the equally narrow margin of 10–0. Although several of their men were twice our age, they were also twice as agile. For the Thirds' part, what we all have is a great deal of enthusiasm and varying degrees of skill. Unilever's set mover outclassed and bypassed us simply and effectively—for here was a team which moved the ball around, and were each always in the right position. Despite this, much of the midfield game was ours. Heal and Lawson (halves) played fast and furiously, whilst the two backs Wood and Ramin gave astonishing accounts of themselves

for a second game-ever! Gildersleve is a courageous and skilled keeper, but the defence was beaten on a few (well, ten) occasions by the superior tactics and cunning of the elder men. Meanwhile, some good pieces of co-ordination up front between Gregson, Selmon, Harris, Down and Harley shone out, but unfortunately never managed to score us a goal. Lost 10–0—but a damn good game! Enjoyed by twenty-two, not eleven!

Andrew Tresidder.

v. Woolwich Royal Artillery. Score: 3–8

From the score-line it may appear that we were soundly beaten. This was true, but not as totally as we would have been if two 1st team players (Karim and Jones) and numerous 2nd's (Hart, Singh, Fellows-Smith, Johnston, Lawson, and Harper), had not been playing.

From the moment of our departure we were doomed: Clive Southgate missed the train and, down to ten men, we arrived at Woolwich, following the sounds of gun-fire and marching-feet.

The teams mustered, we sallied forth, but our ardour was soon dampened, by two early goals put past our unfortunate, non-regular 'goaly', Geoff Ramin. Jones soon responded with a dynamic penalty-flick. Another goal by Seb Johnston followed rapidly and we were back in the game. Not for long though, even hectic defending by Julian (I'm a winger really) Hart, Andy Lawson, Nick Harper and P . . . P . . . Pete Bush were unable to prevent more goals.

At half-time it was decided a new goaly was required and the captain, having been volunteered, proceeded to let in numerous goals (including a trickler that was missed by a memorable ataxic kick directly over the top of the ball.

A cool pass from Jimmy ('hey') (plagiarist-ed) Fellows-Smith led to our final goal, hammered in by Sukhpal Singh.

All in all a most enjoyable game which ended where all good games should, in the bar.

D. Heal.

v. National Westminster 5ths

24th November. Lost 8–0

Yet again the Thirds welcome new players—Julian Alexander and Chris Pillai, new to the side, and Liam Broughton and Mick Foley—new to the game.

(Mick has since gained rapid promotion—'keeper for the Spiro's.) The Nat West were a hospitable side. However, the cricket-score defeat reflects the fact that we had not previously played together as a team.

Nick Cooke showed tireless energy which inspired us all, and the whole team an enthusiasm that waned not for an instant. Not even the regularity of the opposition's goals could dampen this feeling. Nor is it true that your correspondent scored two own-goals in the second half—it was only one!

Team: Southgate, Ramin, Bush, Broughton, Cooke, Tresidder, Foley, Harley, Pillai, Alexander and Down.

A. T.

GOLF

v. King's College Hospital at Dulwich and Sydenham G.C.

Result: Draw 3—3

After a well-earned break, the Guy's team returned to the limelight at the famous Dulwich and Sydenham course, home of Peter Oosterhuis. Nick Page, thinking "Oosty" had returned, was just prevented from kissing the feet of a particularly tall member. We approached the first tee with confidence but doubts began to take root as the usually consistent Palmer fired his first shot on to the road.

Page had trekked all the way from Moor Park just to play and was awarded top spot for his trouble. Unfortunately the journey seemed to have tired him and playing a rather mediocre game he lost convincingly 5 and 4. Palmer played useful golf to discover he had covered the first nine holes in one over par and was still all square. This worried him and he lost 3 and 1. Craigen playing his first match as captain, waited until the last four holes before he woke up and scraped through by one hole. Heard, displaying his new set of irons, (not incidentally belonging to Stuart Matthews) struggled hard but was unable to beat his opponent losing 5 and 4. Harry Brunjes, playing his first match for Guy's, had to play against the same person as Parry because King's only produced five players. Wins by 7 and 6 and 5 and 4 respectively tied the match.

With an expansion of membership and plenty of new blood entering the golf club, Guy's look set to become a real force in London University golf. We look forward to a good run in the Hospital's Cup starting in October, with a good number of useful players to choose from.